

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11313

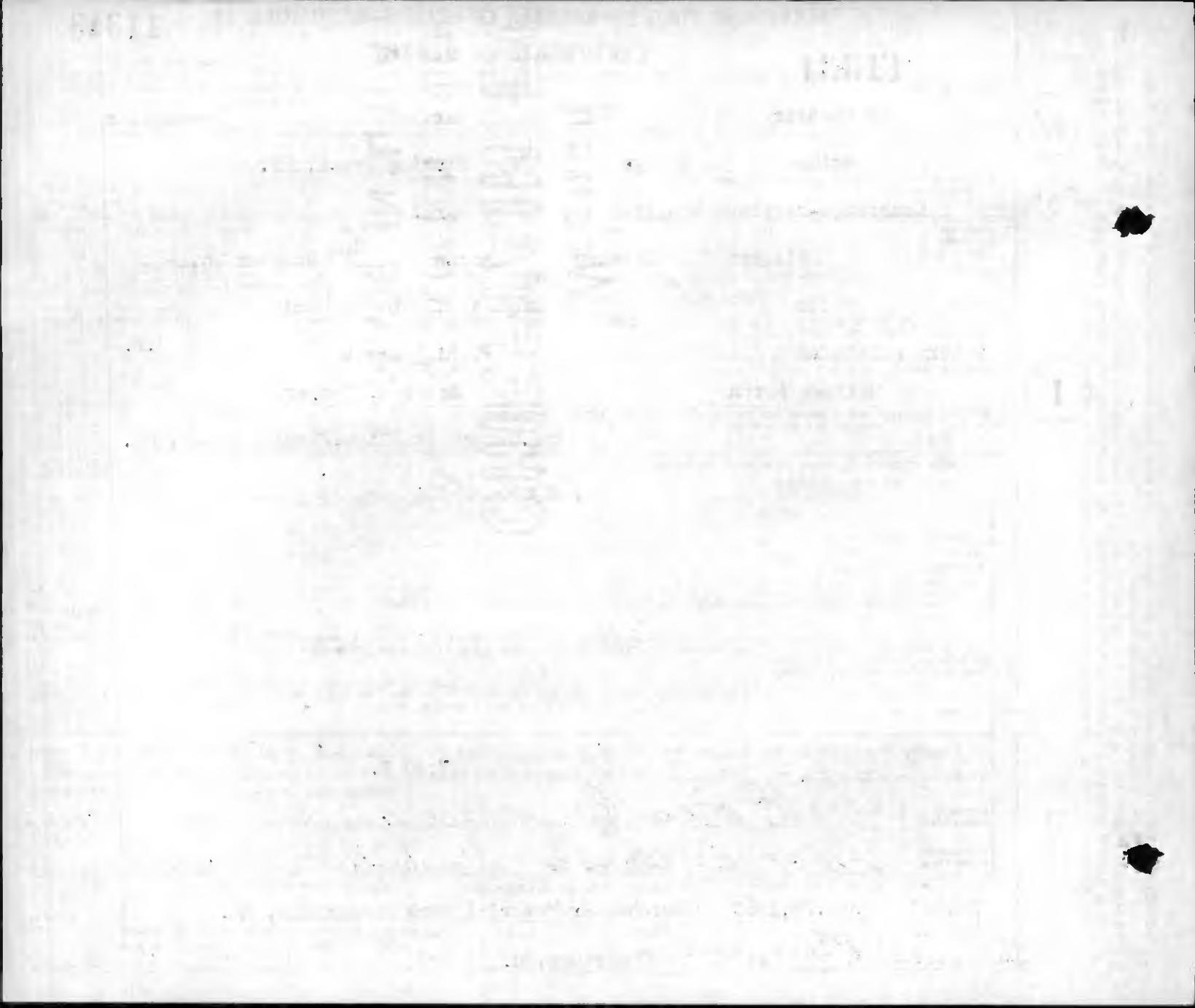
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Wilbert	Middle Matthew	Last Aaron
4. DATE OF DEATH October 26, 1960	Month October	Day 26	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1879
9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. FATHER'S NAME Matthew Aaron	14. MOTHER'S MAIDEN NAME Sarah E. Hooper		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT Mrs. Gorman Phillips, Fishing Creek, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 492X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Coronary Heart Disease	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-27-1960 , to 10-26-1960 , that I last saw the deceased alive on 10-26-1960 , and that death occurred at 7:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Albert E. Bunker, M.D., 200 Maryland Ave.			
ACTUAL SIGNATURE <i>Albert E. Bunker</i>		DATE SIGNED 10/28/60	
PHYSICIAN'S NAME (Type) Albert E. Bunker		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Oct. 29, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park	
22d. LOCATION (City, town, or county) Cambridge, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Horner		24a. REC'D BY REGISTRAR DATE NOV 1 '60	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Albert S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G274 11-14-60 et

11358

11314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 3 mos. 29 Days Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown	
3. NAME OF DECEASED (Type or print) Benjamin F. Anderson		First B	Middle F.
4. DATE OF DEATH Oct 28 1960		Last Anderson	Month Day Year
5. SEX M		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1870		9. AGE (In years lost birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Jefferson Anderson		14. MOTHER'S MAIDEN NAME MARGARET Ann Cantler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 14 1009	
17. INFORMANT Hospital records		Address Cambridge Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 21, 1960 , to OCT 28, 1960 , that I last saw the deceased alive on OCT 27, 1960 , and that death occurred at 5:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thomas J. Dredge, M.D. E.S.S. Hospital, Cambridge, Md.			
DATE SIGNED Oct 28 '60			
ACTUAL SIGNATURE Thomas J. Dredge		PHYSICIAN'S NAME (Type) Thomas J. Dredge	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/60	
22c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery		22d. LOCATION (City, town, or county) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTON FUNERAL SERVICE MD		ADDRESS CAMBRIDGE	24a. REC'D BY REGISTRAR DATE NOV 9 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

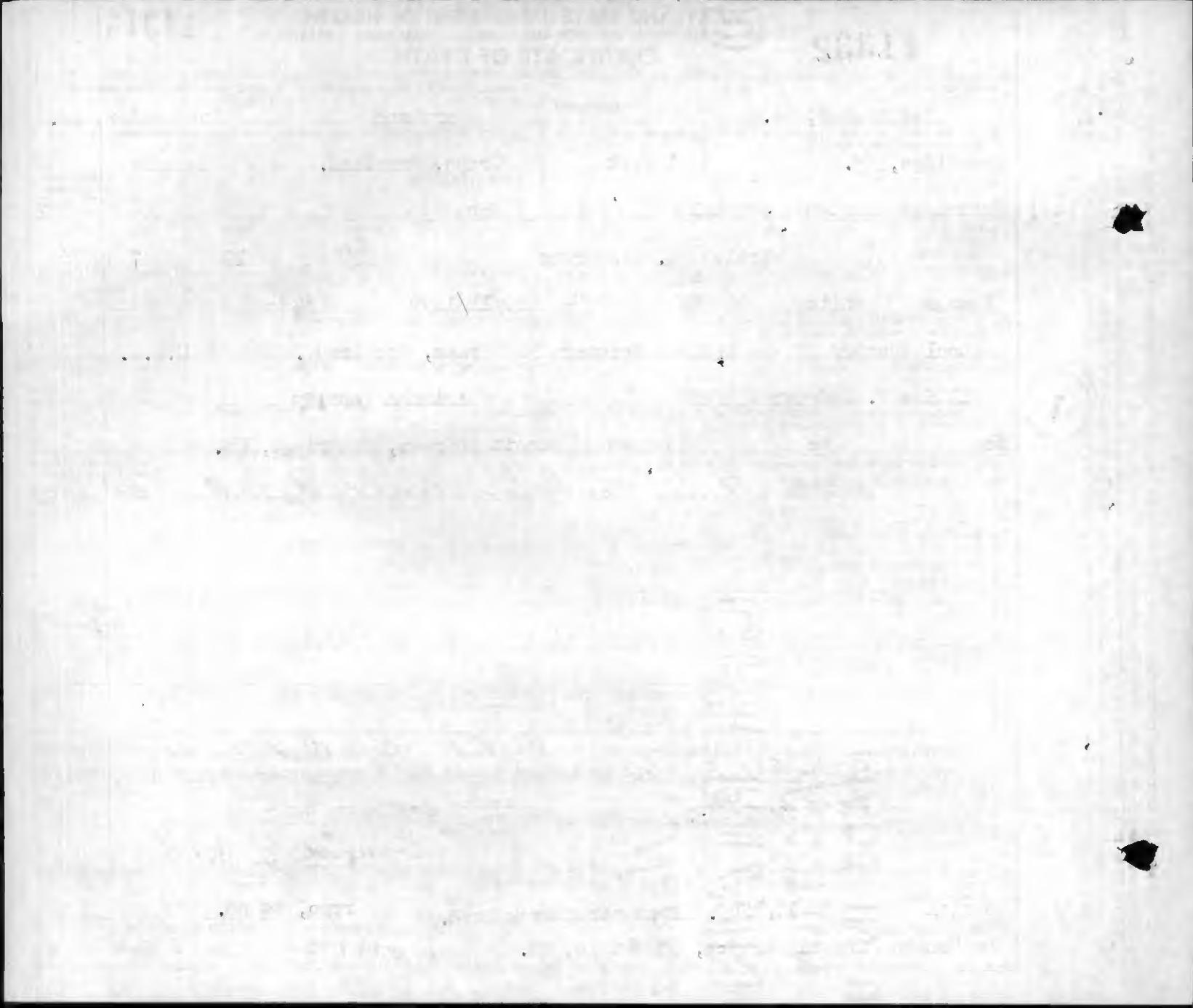
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 printed 11-2-90 at 11332 11315

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crapo, Maryland.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Myrtle E. Andrews		First	Middle
		Last	
4. DATE OF DEATH 10		Month	Day
		Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 10/11/1899	
9. AGE (In years last birthday) 16661 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	
11. BIRTHPLACE (State or foreign country) Crapo, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Andrews		14. MOTHER'S MAIDEN NAME Arianna Insley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Emeett Andrews, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] 082-3 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) DUE TO DUE TO DUE TO Encephalitis, acute, Viral 6 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1 1960 to Oct 7 1960 . (I) (we) last saw the deceased alive on Oct 7 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE M. E. Andrews		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/1960	23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer Church Yard
23d. LOCATION (City, town, or county) Crapo, Crapo, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Thorne



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11333 CERTIFICATE OF DEATH 12494

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> None	
3. NAME OF DECEASED (Type or print) Richard		First W.	Middle Andrews
4. DATE OF DEATH 10 30 1960	Month 10	Day 30	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1904
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Waterman	
11. BIRTHPLACE (State or foreign country) Maryland, Dorchester, Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ellsworth Andrews		14. MOTHER'S MAIDEN NAME Anne Willey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 10/23/42 2/6/43 212-16-5036	
17. INFORMANT Mrs. Richards Andrews, Lloyds, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 542.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH Bleeding gastro-jejunal ulcer few days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5 1960 to Oct 30 1960 that (I) (we) last saw the deceased alive on Oct 30 1960 and that death occurred at 4 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Lewis M. Burdette		22b. DATE SIGNED 11/1/60	
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1 Locust St, Cambridge, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/1960.	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
		25b. REGISTRAR'S SIGNATURE Charles E. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11335

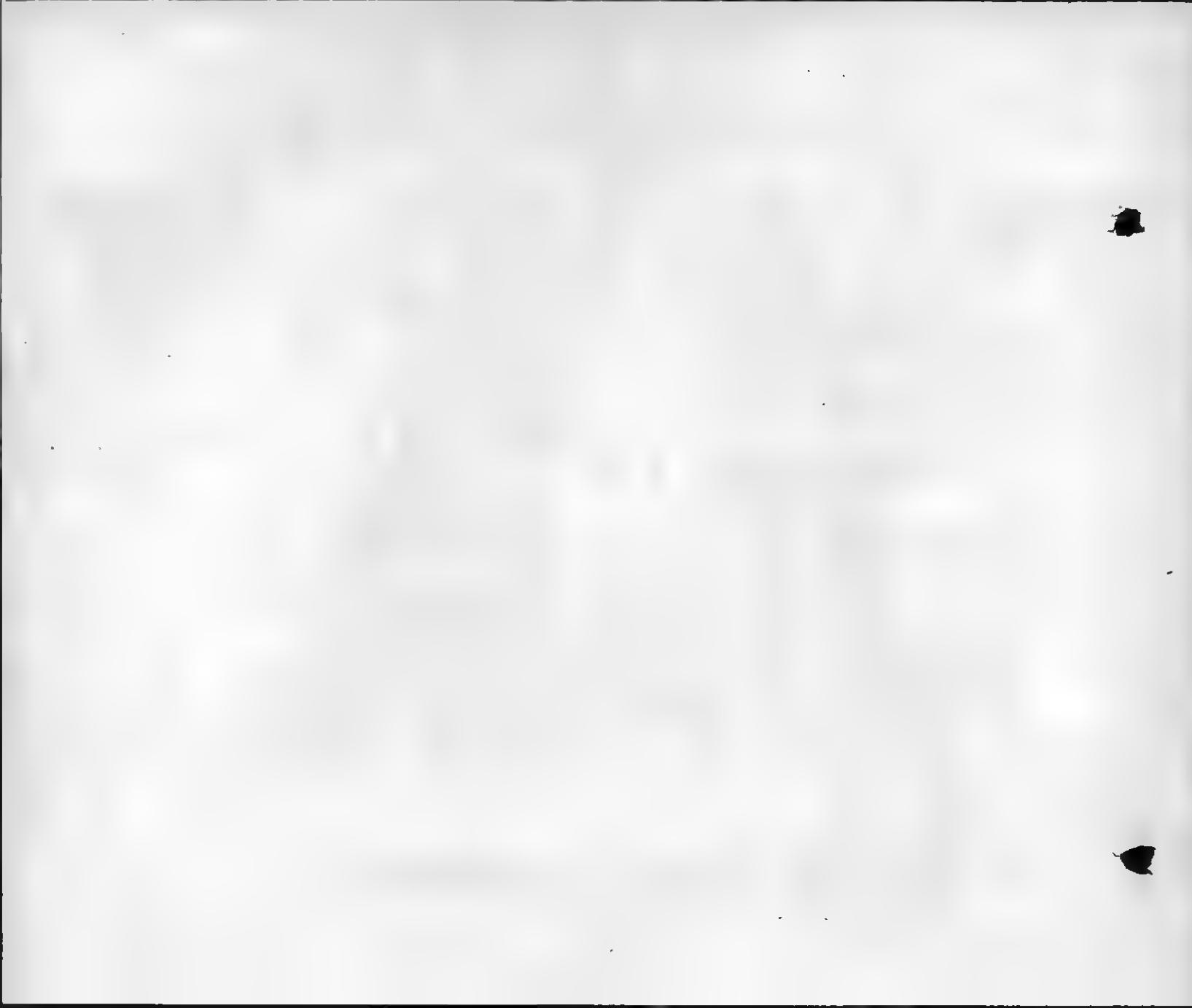
11317

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS Near Zion	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First: Grover Middle: Cleveland Last: Corkran, Sr.		4. DATE OF DEATH Month October Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Paper hanging	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher C. Corkran		14. MOTHER'S MAIDEN NAME Eliza Andrew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Elsie R. Corkran, Hurlock, Maryland, R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock INTERVAL BETWEEN ONSET AND DEATH 1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck left femur, 8, 9, 10th ribs 2 days			
DUE TO (b) Fracture neck left femur, 8, 9, 10th ribs 2 days			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed.	
20c. TIME OF INJURY Hour 9 — p.m. Month, Day, Year 10/26/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hurlock Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace, Jr.</i>		DATE SIGNED 10-31-60	
EXAMINER'S NAME (Type) John Mace, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Zion Cemetery		22d. LOCATION (City, town, or county) Near Williamsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE NOV 7 '60	
		24b. REGISTRAR'S SIGNATURE Orilia S. Thomas	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

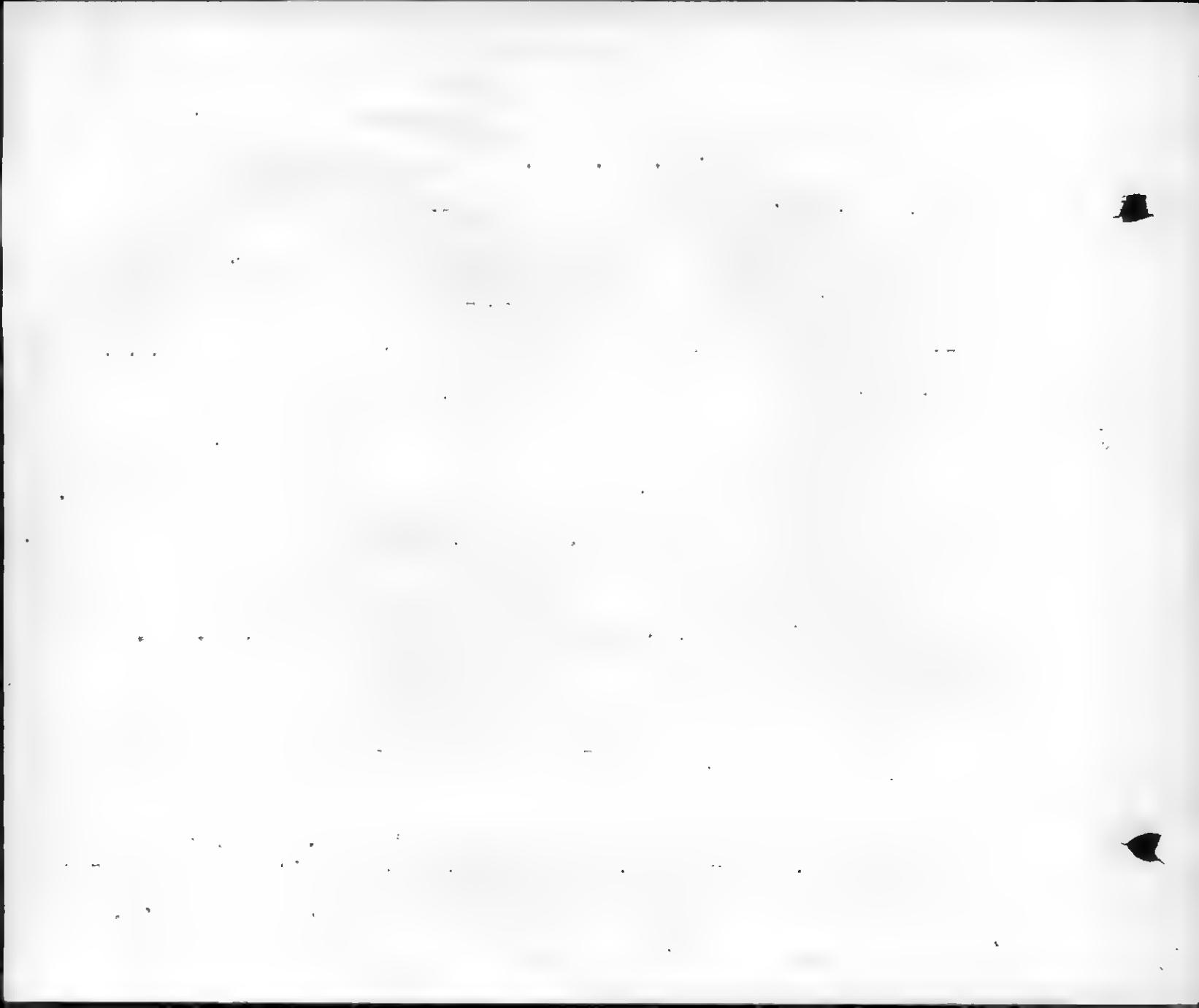
11359

CERTIFICATE OF DEATH

11318.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE	
Dorchester MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 4 yrs. 3 mos. 11 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barksdale	
d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Elizabeth	Middle Fairo
4. DATE OF DEATH		Last DeVinney	Month October Day 22 Year 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	8. DATE OF BIRTH 7-05-81
9. AGE (In years last birthday)		79 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George DeVinney		14. MOTHER'S MAIDEN NAME Georgianna Knotts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. INFORMANT Address Eastern Shore State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 42061 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 15 mins.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized Arteriosclerosis over 4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Senile Brain Disease W. Psy. Reac.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-24, 1957, to 10-22, 1960, that I last saw the deceased alive on 10-22, 1960, and that death occurred at 12:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Harry J. Crawford		M.D.	
PHYSICIAN'S NAME (Type) Harry J. Crawford, M.D.		Eastern Shore State Hospital Cambridge, Maryland 10-22-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/60	
22c. NAME OF CEMETERY OR CREMATORIAL Head of Christiana Cemetery, Newark, Del.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, Elston, M.D.		24a. REC'D BY REGISTRAR DATE OCT 26 '60	
		24b. REGISTRAR'S SIGNATURE Charles S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11336

CERTIFICATE OF DEATH

11319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Few Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market	
3. NAME OF DECEASED (Type or print) Lillian Eliz. Young Dockins		4. DATE OF DEATH Oct. 6, 1960	Month Day Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Mar. 23, 1907	9. AGE (In years lost birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
10c. BIRTHPLACE (State or foreign country) Dorchester County, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Young		14. MOTHER'S MAIDEN NAME Emma V. Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 213-18-6030	
17. INFORMANT Marcellus Dockins, East New Market, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Uremia	
		b) Hypertensive Cardiovascular Renal Disease	
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 16, 1960 , to October 6, 1960 , that I last saw the deceased alive on October 6, 1960 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Actual Signature 10-8-60			
22. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/1960	
22c. NAME OF CEMETERY OR CREMATORIAL East New Market		22d. LOCATION (City, town, or county) Dorchester County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Verber McElroy		24a. ADDRESS Cambridge, Md.	
		24b. REC'D BY REGISTRAR DATE OCT 18 '60	
		24c. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 1110277 12-21-60 et

11337

11320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Few Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Dockins	4. DATE OF DEATH	Month Oct.	Day 29,	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Approx.	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS. Days 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Camper		14. MOTHER'S MAIDEN NAME Catherine Fisher		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT			
				Marcellus Dockins, East New Market, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Heart Disease					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>420-1</i>		DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 227 Pine St (State) Cambridge, Md.	
21. I certify that I attended the deceased from October 22 1960 to October 29, 1960 , that I last saw the deceased alive on October 29, 1960 , and that death occurred at M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		DATE SIGNED 10-31-60					
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/1960		22c. NAME OF CEMETERY OR CREMATORIAL East New Market		22d. LOCATION (City, town, or county) Dorchester County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbelle M. Ellsworth</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR NOV 9 1960		24b. REGISTRAR'S SIGNATURE Linus J. Moran	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death: Page 1
may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11321

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 Day		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester, Co.	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 418 Henry, Street.			
						d. STREET ADDRESS Cambridge, Maryland.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> KK	
3. NAME OF DECEASED (Type or print) Edward		First	Middle	Last	4. DATE OF DEATH 10 19 1960	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/1889		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) Caroline, Co. Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Dunn				14. MOTHER'S MAIDEN NAME Ellen Tall					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Edward Dunn., 418 Henry, St. Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) H2O.		CEREBRAL HEMORRHAGE							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause ast. (b)		ARTERIOSCLEROSIS							
DUE TO DUE TO DUE TO		CORONARY HEART DISEASE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-24-58 , 19, to 10-19-60 , 19, that (I) (we) last saw the deceased alive on 10-18-60 , 19, and that death occurred at M. from the causes and on the date stated above									
22a. SIGNATURE <i>Albert E. Bunker</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-21-60		
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M.D.		22d. ADDRESS 200 MARYLAND AVE, CAMBRIDGE, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/1960.		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		23d. LOCATION (City, town, or county) Cambridge, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Le Compte Funeral Service, Cambridge, Md.</i>		25a. REC'D BY REGISTRAR 4 60							
		25b. REGISTRAR'S SIGNATURE <i>Le Compte</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11339

11322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 191 Washington Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
f. STREET ADDRESS 191 Washington Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lulu	Middle Elizabeth	Last Earles
4. DATE OF DEATH	Month Oct.	Day 27,	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
10c. FATHER'S NAME John H. Earles		11. BIRTHPLACE (State or foreign country) Cambridge, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. MOTHER'S MAIDEN NAME Susan Mariah Henry	
14. ADDRESS No		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 216-18-8938		17. INFORMANT Jessie Earles, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease			
DUE TO 434-4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
DUE TO Cardiac Decompensation			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day, Year Not white at work <input type="checkbox"/> at work <input type="checkbox"/>
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1960 , to October 27, 1960 , that I last saw the deceased alive on October 27, 1960 , and that death occurred at 10 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		ADDRESS (Street, city or town, state) M.D. 227 Pine St-Cambridge, Md.	
DATE SIGNED 10-29-60			
22. MEDICAL CERTIFICATION PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert McCallum</i>		24a. REC'D BY REGISTRAR DATE NOV 9 '60	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Khan	

A

B

C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11340

CERTIFICATE OF DEATH

11323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 13		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS Moores Avenue Ext'd	
3. NAME OF DECEASED (Type or print) Joyce		First Edwards	Middle Edwards
4. DATE OF DEATH Oct. 19, 1960	Month Oct.	Day 19	Year 1960
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1959
9. AGE (In years from birth) 1 yrs.	10. IF UNDER 1 YEAR 4 Months	11. IF UNDER 24 HRS 4 Days	12. IF UNDER 24 HRS 4 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Warren Edwards		14. MOTHER'S MAIDEN NAME Ornie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give rank or date of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Ornie J. Edwards, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0			
DUE TO TOXEMIA			
INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. ACUTE GASTRO-ENTERITIS			
DUE TO 7 DAYS			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 136 RACE ST
(County) Cambridge		(State) Maryland	
21. I certify that I attended the deceased from 10/11 , 1960, to 10/18 , 1960, that I last saw the deceased alive on 10/18 , 1960, and that death occurred at 5 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) CAMBRIDGE, MD			
DATE SIGNED 10/21/60			
ACTUAL SIGNATURE Alfred R. Maryanov		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 10/21/1960		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	
22d. LOCATION (City, town, or county) Cambridge, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Wallace Jr.		24a. REC'D BY REGISTRAR DATE NOV 9 '60	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

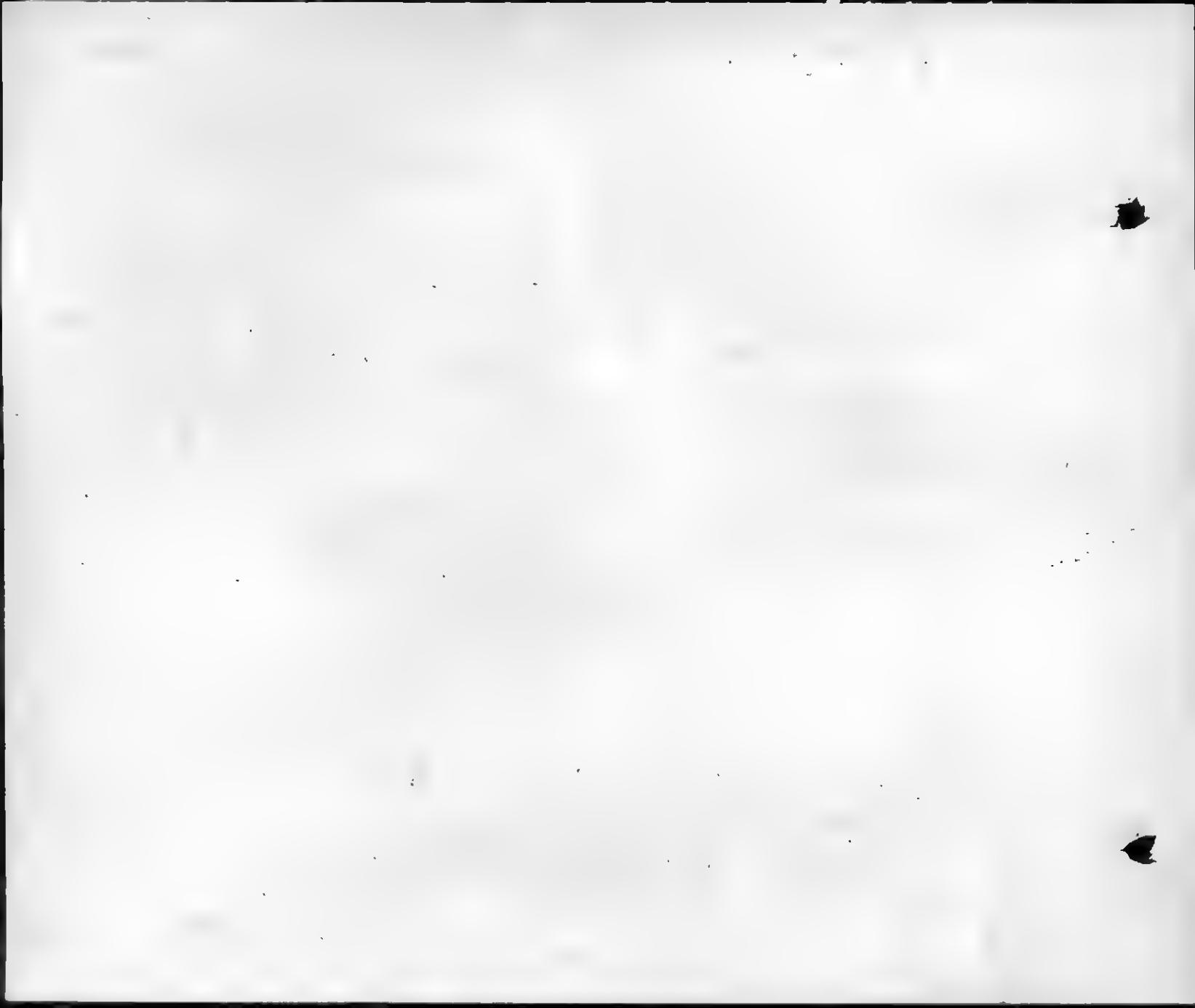
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11324

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Dor</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>	c. LENGTH OF STAY IN 1b <i>4 yrs</i>	b. COUNTY <i>MD</i>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Penobscot Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>	
d. STREET ADDRESS <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Lizzie Spear</i>	First	Middle	Last <i>Ellis</i>
4. DATE OF DEATH <i>10/1/81</i>	Month <i>10</i>	Day <i>1</i>	Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/18/1873</i>
9. AGE (In years last birthday) yrs. <i>87</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Haircutter- Ret</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Haircutter</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Franklin Spear</i>	14. MOTHER'S MAIDEN NAME <i>Loreca Shorty</i>	15. ADDRESS <i>Mr. and Mrs. Franklin Spear 200 Franklin Street St. Michaels, Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. (If yes, give war or date of service) <i></i>	17. INFORMANT <i>Mr. and Mrs. Franklin Spear</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute left ventricular failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Generalized arteriosclerosis</i>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Right cerebral hemorrhage & left paroxysm</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>11-21</i> , 19 <i>57</i> , to <i>10-8</i> , 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>10-7</i> , 19 <i>60</i> and that death occurred at <i>9:45</i> A.M. from the causes and on the date stated above			
22a. SIGNATURE <i>Lizzie Spear</i>	M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>10-11-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Lizzie H. B. Plummer</i>	22d. ADDRESS <i>200 Franklin Street St. Michaels, Md.</i>		
23a. BUR. A., CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/12/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Penobscot</i>	23d. LOCATION (City, town, or county) <i>St. Michaels, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Hollingsby, East New Market</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>AT OCT 17 '60</i>	25b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 to 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11341 CERTIFICATE OF DEATH

11325

Reg. Dist. No.

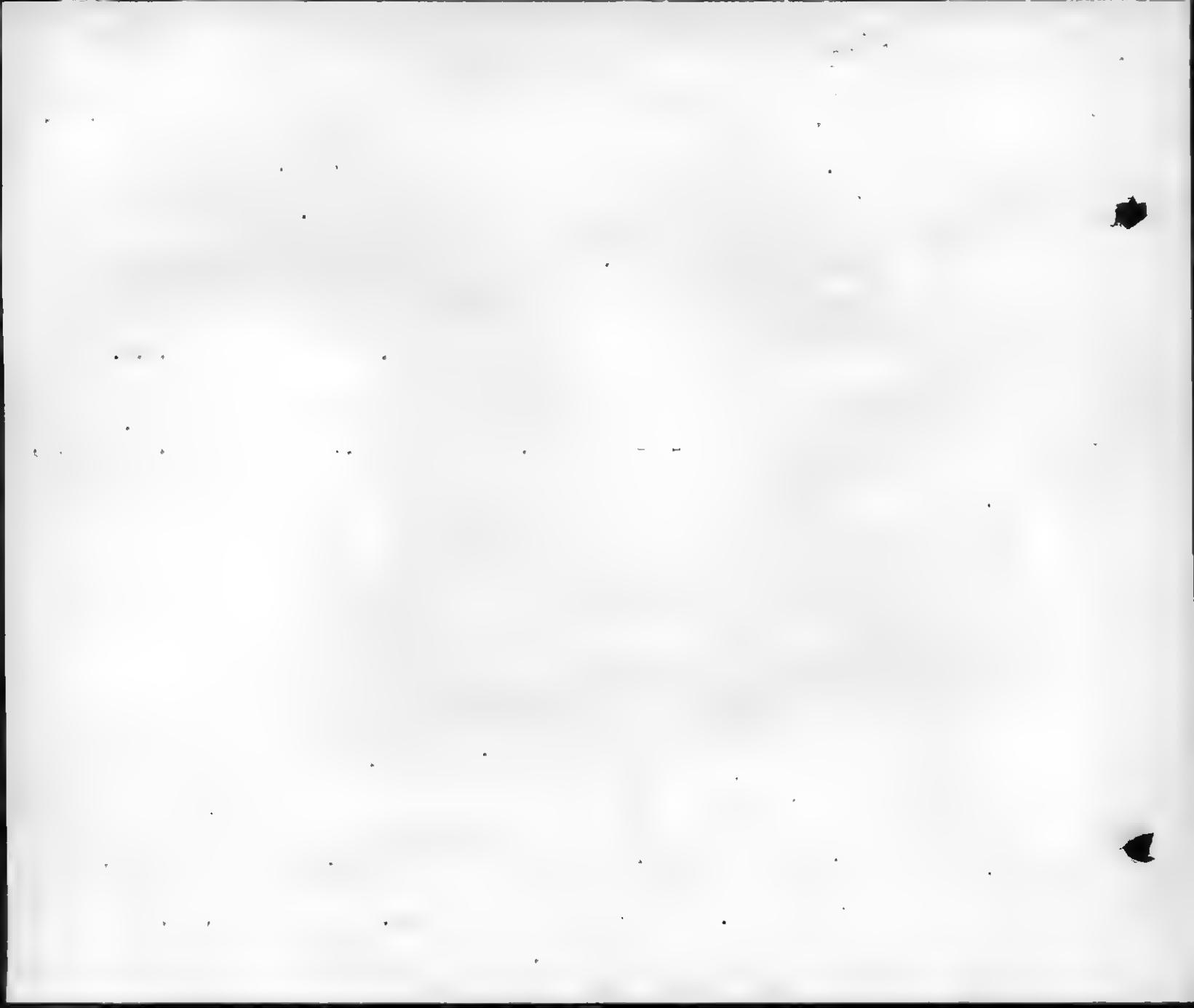
1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) B Cambridge		d. STREET ADDRESS 11 Dobson Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Dobson Street				d. STREET ADDRESS 11 Dobson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle James	Last Ennals	4. DATE OF DEATH Oct. 23, 1960	Month Oct.	Day 23	Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 28, 1894	9. AGE (in years from birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ennals				14. MOTHER'S MAIDEN NAME Elizabeth Burruoghs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Ruth Ennals, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199-2 Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1960, to October 23, 1960, that I last saw the deceased alive on October 23, 1960, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>J. Edwin Fassett</i> DATE SIGNED 10-25-60							
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/1960		22c. NAME OF CEMETERY OR CREMATORIAL Vaugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert W. Fassett</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR NOV 9 '60		24b. REGISTRAR'S SIGNATURE Charles L. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11326

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		d. STREET ADDRESS 307 Henry, Street.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilfred		First T.	Middle Gatton	Last 	4. DATE OF DEATH 10/11/1960	Month 10	Day 11	Year 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1879		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Gatton				14. MOTHER'S MAIDEN NAME Jennie Gatton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-10-0973		17. INFORMANT Mrs. Stella Gatton, 307 Henry, St. Cambridge,		Address Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident.						INTERVAL BETWEEN ONSET AND DEATH 4 days			
33 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 1 X		DUE TO (b) 							
DUE TO (c) 									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1960, to Oct. 11, 1960, that (I) (we) last saw the deceased alive on Oct. 11, 1960, and that death occurred at 10M, from the causes and on the date stated above									
22a. SIGNATURE Gatton Mace Jr.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/13/60	
22c. PHYSICIAN'S NAME (Type) Dr. John Mace Jr.		22d. ADDRESS 5 Church St. Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/1960		23c. NAME OF CEMETERY OR CREMATORIAL PARK Dorchester Memorial Park		23d. LOCATION (City, town or county) Cambridge, Md.		(State) 	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		ADDRESS		25a. REC'D BY REGISTRAR 		25b. REGISTRAR'S SIGNATURE Caroline S. Hayes			
				DATE OCT 17 '60					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 7, 11, 12, 14, 11-17-60 et

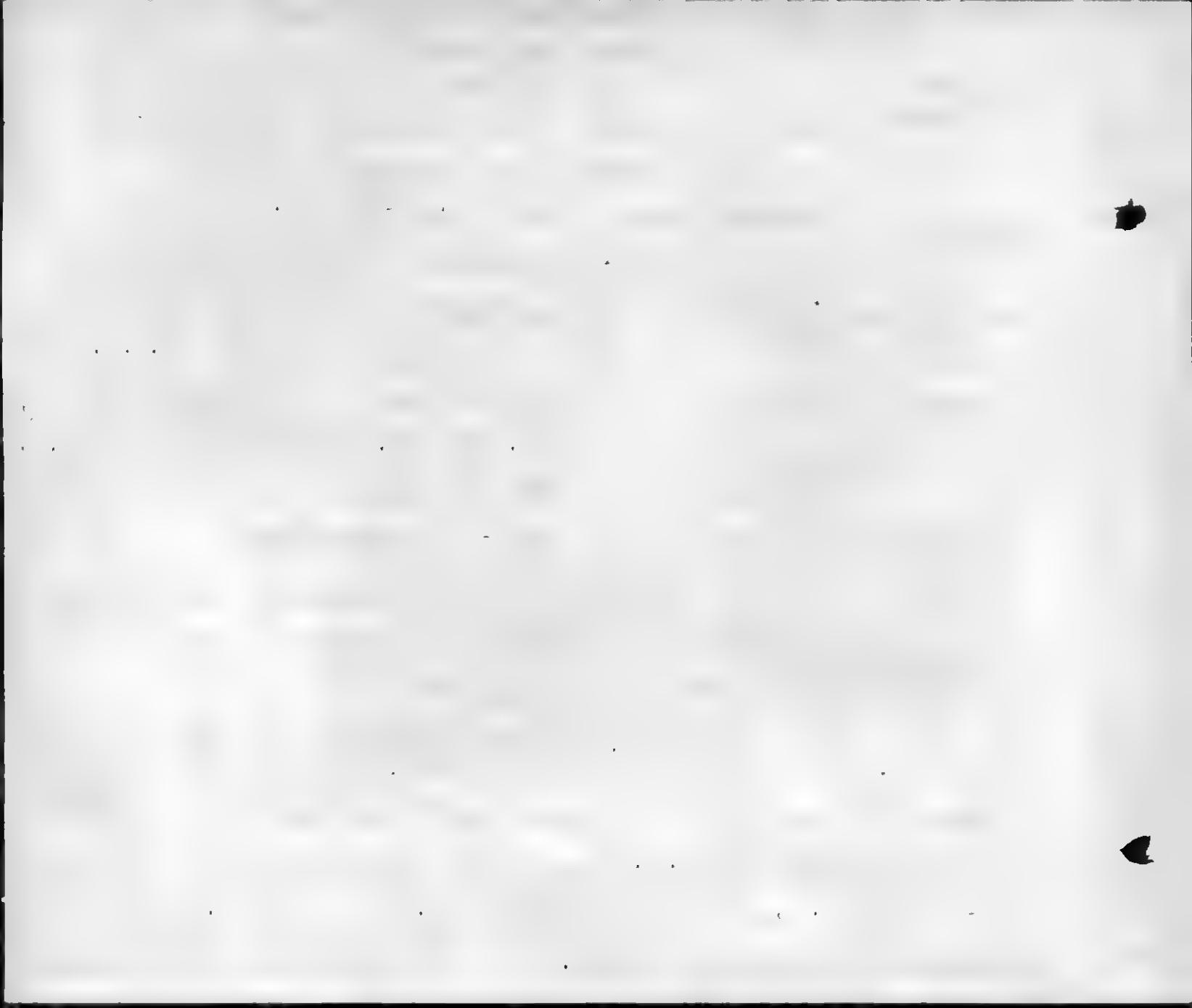
11343

CERTIFICATE OF DEATH

11327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland Hospital		d. STREET ADDRESS 2602 N. Pershing Dr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Frank		First W.	Middle Goodsell	Last W.	4. DATE OF DEATH Oct 28 1960	Month Oct	Day 28	Year 1960	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNK <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1882	9. AGE (In years lost birthday) yrs. 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairyman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 578-03-5297 Mrs. George T. Costello		Address 4454 Greenwich Pk'y Washington 7, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Mesenteric Thrombosis									
442 DUE TO Condition, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular-Renal Disease									
DUE TO (c) Arteriosclerosis, Generalized									
INTERVAL BETWEEN ONSET AND DEATH 30 hours									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic & Acute Cardiac & Renal Failure, 10 days +									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge, Maryland		(County) Md.	(State) Md.
21. I certify that I attended the deceased from Oct. 17th, 1960, to Oct. 28th, 1960, that I last saw the deceased alive on Oct. 28th, 1960, and that death occurred at 7:00 A.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Maryland									
DATE SIGNED 10/28/60									
ACTUAL SIGNATURE Eldridge H. Wolff									
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens Cem.		22d. LOCATION (City, town, or county) Arlington, Va.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service				ADDRESS Cambridge		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
						DATE NOV 3 '60			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11344

12502

1. PLACE OF DEATH
a. COUNTY

Dorchester Co.

b. CITY OR TOWN (If outls. do corporate limits,
write RURAL and give nearest town)

Cambridge, Maryland.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge Maryland Hospital

3. NAME OF
DECEASED
(Type or print)

MARYLAND

c. LENGTH OF STAY IN 1b

10 Years

5. SEX

Lorraine Duck Harmon

Female

6. COLOR OR RACE
7. MARRIED NEVER MARRIED 8. DATE OF BIRTHWhite WIDOWED DIVORCED

10/5/1909

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Case Worker

10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)

Welfare Board

Greenville, Texas.

13. FATHER'S NAME

Charles A. Buck

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or details of service)

No.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary occlusion

420-1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

10/31/60

Address (Street, city, town, or county)

(State)

22a. BURIAL/CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country)

(State)

Burial
23. FUNERAL DIRECTOR

10/31/1960.

Dorchester Memorial Park.

ADDRESS

Cambridge, Maryland.

24a. REC'D BY REGISTRAR

(State)

Le Compte Funeral Service, Cambridge, Maryland.

24b. REGISTRAR'S SIGNATURE

(Signature)

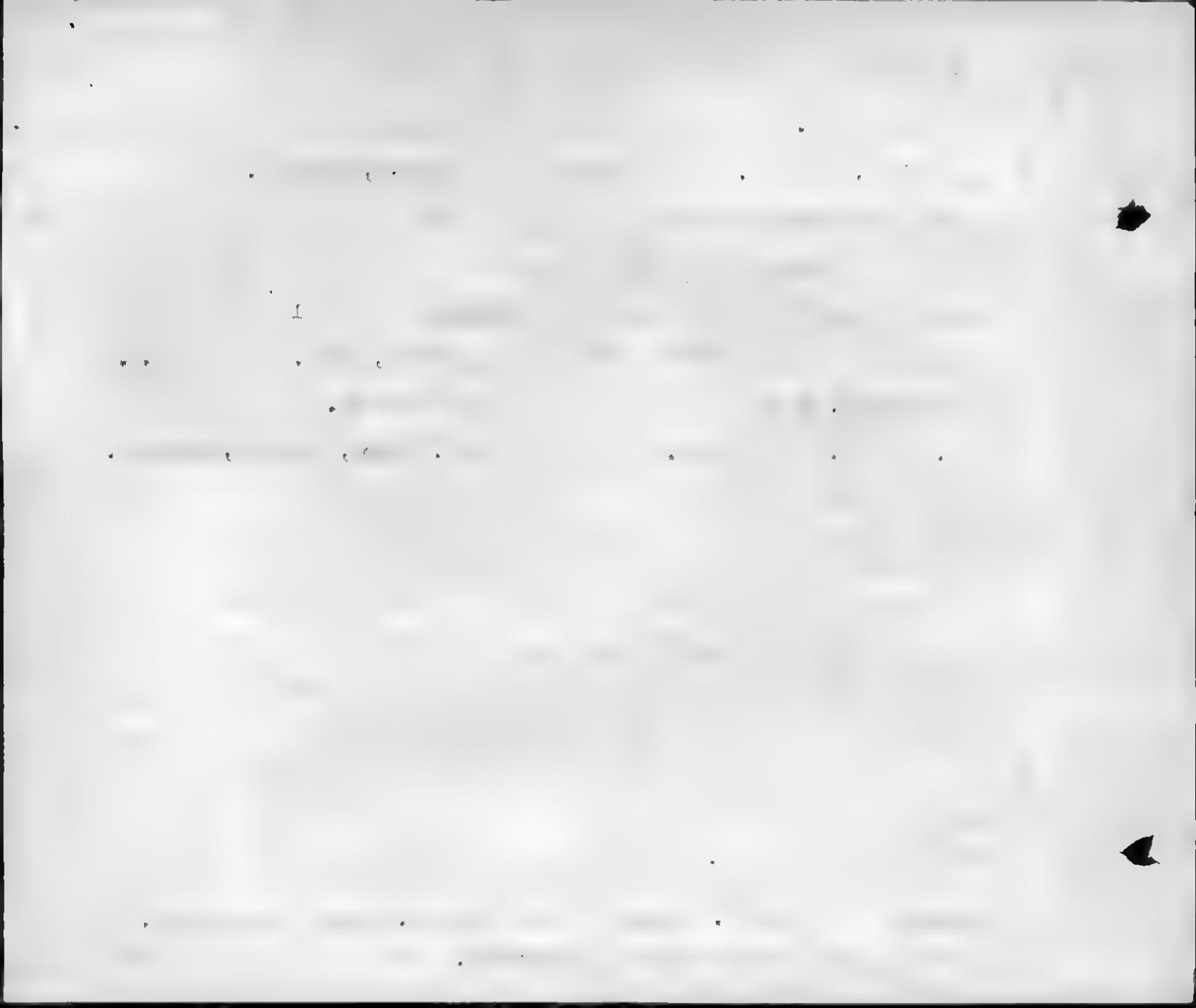
DATE NOV 9 '60

Orlina S. Trahan

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
5M 7/59



FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11328

1. PLACE OF DEATH

a. COUNTY

Dorchester

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Maryland hospital, D.C.

3. NAME OF
DECEASED
(Type or print)

First
John

Middle
Henry

Last
Hooper

5. SEX

Male

6. COLOR OR RACE
Negro

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 12, 1896

9. AGE (In years
last birthday)

63
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

12a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

12b. KIND OF BUSINESS OR INDUSTRY

General

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Hooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

217-09-129 Mrs. Gertrude Hooper Taylors Island,

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420-1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

1 hr.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

10/15/60

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)
Dr. John Pace Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or country) (State)
Burial 10/15/60 Taylors Island Cemetery Taylors Island, Dor. Md.

23. FUNERAL DIRECTOR

ADDRESS
Herbert St Clair Cambridge, Md.

24a. RECEIVED BY REGISTRAR

OCT 18 '60

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11329

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>All life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Clive</i>	Middle <i>George</i>	Last <i>Hawkins</i>
4. DATE OF DEATH Month <i>10</i> Day <i>17</i> Year <i>1960</i>	5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>1/7/1893</i>	9. AGE (In years last birthday) <i>67</i> yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USWA/OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stock broker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Broker</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Hawkins</i>	14. MOTHER'S MAIDEN NAME <i>Lucia Layton</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> 16. SOCIAL SECURITY NO. (Yes, no, or unknown) <i>(If yes, give war or date of service)</i>	
17. INFORMANT <i>Physician</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Artery Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i> 19. INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Obesity</i>	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1077 19th St. Baltimore</i>	20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>10/17/1960</i> to <i>10/17/1960</i> , that (I) (we) last saw the deceased alive on <i>10/17/1960</i> , and that death occurred at <i>1077 19th St. Baltimore</i> , M. from the causes and on the date stated above.		22a. SIGNATURE <i>W.H. Hawkins</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.H. Hawkins</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>10/17/60</i>	
23a. BURIAL, CREMAT. ON REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/17/1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ellicott</i>	23d. LOCATION (City, town, or county) <i>Ellicott</i> (State) <i>Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Layton</i>	ADDRESS <i>1077 19th St. Baltimore</i>	25a. REC'D BY REGISTRAR DATE <i>OCT 27 1960</i>	25b. REGISTRAR'S SIGNATURE <i>John S. Layton</i>



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11346 11330

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbridge</i> <i>Woodbridge</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lawrence Hospital</i> <i>Montgomery, Maryland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Robert</i>	First <i>Robert</i>	Middle <i>Robert</i>	Last <i>Robert</i>	
4. DATE OF DEATH <i>10/25/1964</i>	Month <i>10</i>	Day <i>25</i>	Year <i>1964</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/10/1884</i>	
9. AGE (In years day/birthday) <i>80 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Businessman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Businessman</i>	11. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Haisman</i>	14. MOTHER'S MAIDEN NAME <i>Marie Pauline</i>	Address <i>101 Marie Pauline, Baltimore</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>444-12-1212</i>	17. INFORMANT <i>Mr. Maurice Pauline, Baltimore</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Insufficiency Coronary Heart Disease	19. INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/25/1964</i> to <i>10/27/1964</i> , that (I) (we) last saw the deceased alive on <i>10/27/1964</i> and that death occurred at <i>500 M</i> , from the causes and on the date stated above	22a. SIGNATURE <i>Lawrence Maryanov</i>	22b. DATE SIGNED <i>10/29/1964</i>	22c. PHYSICIAN'S NAME (Type) <i>Lawrence Maryanov</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/25/1964</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cambridge</i>	23d. LOCATION (City, town, or county) <i>Cambridge</i>	(State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Murphy</i>	ADDRESS <i>101 Marie Pauline, Baltimore</i>	25a. REC'D BY REGISTRAR <i>NOV 3 '60</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial/transit permit. Then please remove/carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11347 CERTIFICATE OF DEATH

11331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Cedar Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Elizabeth Manokey		First	Middle
4. DATE OF DEATH Oct. 26, 1960		Last	Month
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 30, 1866		9. AGE (In years lost birthday) 94 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Manokey		14. MOTHER'S MAIDEN NAME Millie Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 212-16-7688	
17. INFORMANT George Manokey, Baltimore, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
434.4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cardiac Decompensation		DUE TO	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on		July 1, 1960, to October 26, 1960, that I last saw the deceased and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		DATE SIGNED 10-27-60	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/1960	
22c. NAME OF CEMETERY OR CREMATORIUM Old Field Cemetery		22d. LOCATION (City, town, or county) Dorchester County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb M. Fassett</i>		ADDRESS Cambridge, Md.	
		24a. REC'D BY REGISTRAR DATE NOV 9 '60	
		24b. REGISTRAR'S SIGNATURE <i>Robert S. Kraus</i>	



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

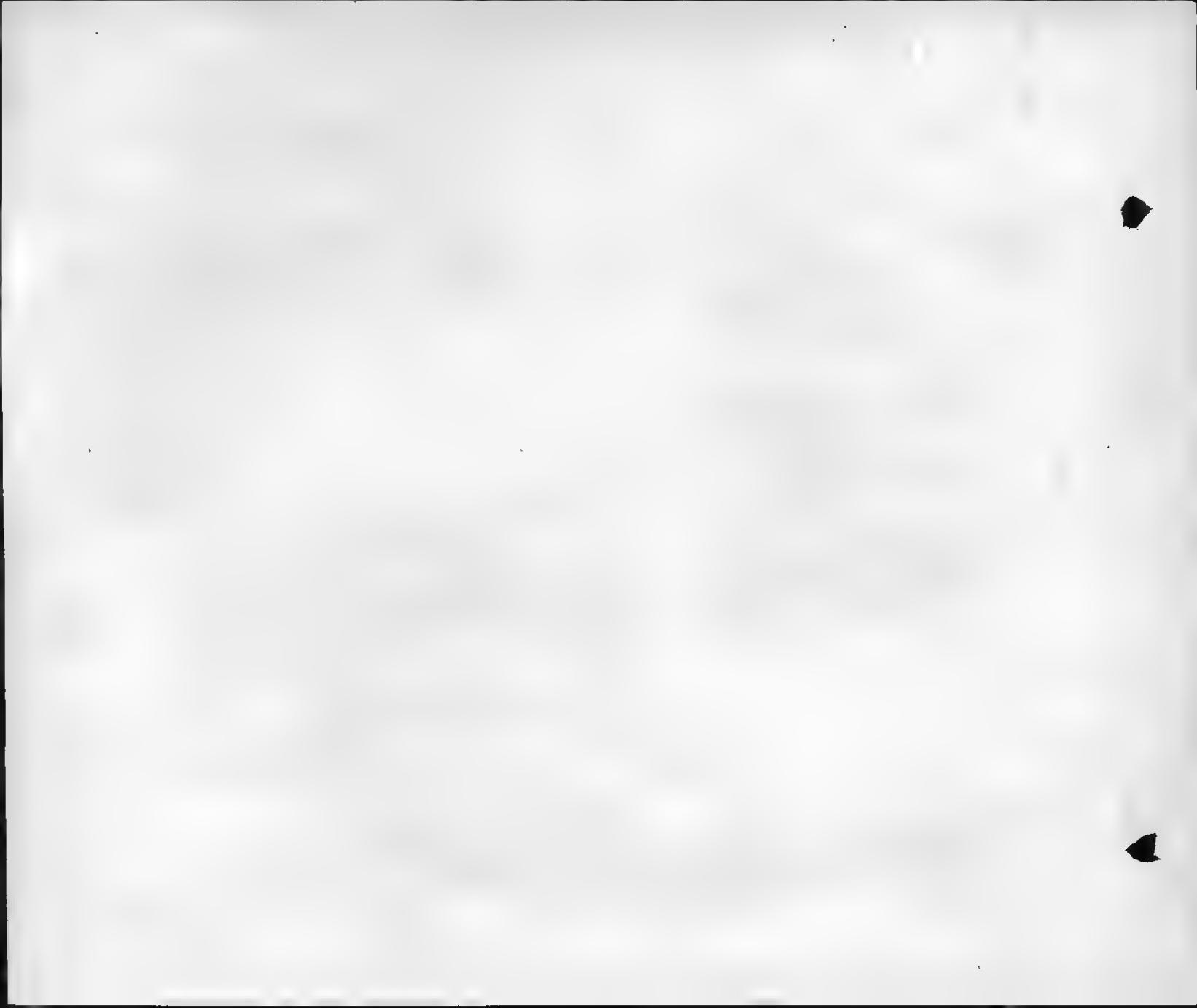
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rhodesdale		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rhodesdale	
3. NAME OF DECEASED (Type or print)		First John	Middle Wesley
4. DATE OF DEATH October 11 1960		5. SEX Male	6. COLOR OR RACE Negro
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 220-05-1874	
17. INFORMANT Mrs. Edna Lofland		Address RFD-Rhodesdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John Mace</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1013/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Johns Cemetery		22d. LOCATION (City, town, or county) (State) Caroline County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR OCT 18 '60		24b. REGISTRAR'S SIGNATURE C. J. Frampton	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11363

CERTIFICATE OF DEATH

11383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Church Creek		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Church Creek		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle 	Last Matney	4. DATE OF DEATH	Month Oct.	Day 24	Year 1960
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 23, 1868	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Matney		14. MOTHER'S MAIDEN NAME Mariah Thompson		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elisha Matney, Cambridge, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420-0		DUE TO Cardiac Decomposition		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerotic heart disease					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1958 to October 24, 1960 that I last saw the deceased alive on October 24, 1960 and that death occurred at M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>				M.D. 227 Pine St—Cambridge, Md.		10-25-60	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/1960		22c. NAME OF CEMETERY OR CREMATORIUM Meekins Neck Ceme.		22d. LOCATION (City, town, or county) Dorchester County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb M. Hall Jr.</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director.



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

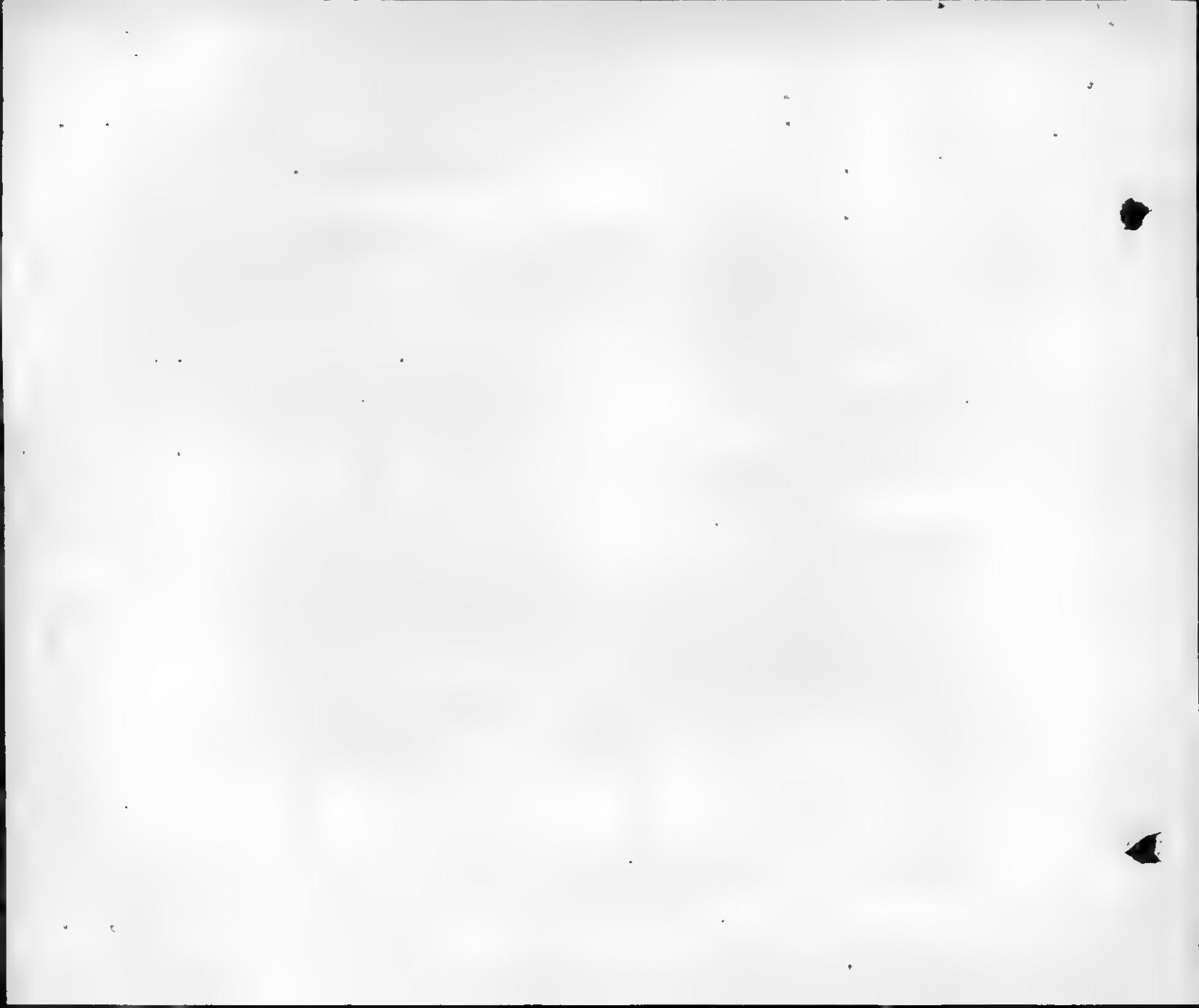
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11334

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland		b. COUNTY Dorchester, Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		d. STREET ADDRESS 503 Race, Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 503 Race, St.				d. STREET ADDRESS 503 Race, Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Willie Gore		First Willie	Middle Gore	Last Meredith	4. DATE OF DEATH 10 17 1860	Month 10	Day 17	Year 1860
S SEX Fema le	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	B. DATE OF BIRTH 5/10/1865	9. AGE (In years last birthday) 95	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Edward Gore								
14. MOTHER'S MAIDEN NAME Margaret Ann Gore								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service No								
16. SOCIAL SECURITY NO. No 17. INFORMANT Miss Ruby Meredith, 503 Race, St. Cambridge, Md. Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431 X DUE TO MYOCARDIAL FAILURE INTERVAL BETWEEN ONSET AND DEATH 5 days Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) TOXIC MYOCARDITIS 8 days (c) Widespread Decubitus ulcers								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 6/10 1960 to 10/17 1960	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 6/10 1960 to 10/17 1960 that (I) (we) last saw the deceased alive on 10/17 1960 and that death occurred 10 AM , from the causes and on the date stated above								
22a. SIGNATURE W. H. Flanks, M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/18/60	
22c. PHYSICIAN'S NAME (Type) W. H. Flanks, M.D.		22d. ADDRESS CAMBRIDGE MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/1960		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS East New Market		23d. LOCATION (City, town, or county) Cambridge, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service				25a. REC'D BY REGISTRAR DATE NOV 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knapp		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1134-1135

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Calvert	
c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hosp.		d. STREET ADDRESS Route 22	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Andrew Mills	First	Middle	Last
4. DATE OF DEATH March 12, 1960	Month	Day	Year 1960
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1885
9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 14	12. IF UNDER 24 HRS Hours 14 Min. 00
10a. US LAB. OCCUPATION (Give kind of work done during most of working life, even if retired) Saintor		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Mills		14. MOTHER'S MAIDEN NAME Johanna Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 163-18-2269	
17. INFORMANT Alice Mills Trappe		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420			
DUE TO Cardiac Decompression			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease			
DUE TO (c) Bronchopneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) — (County) — (State) —	
21. I certify that (I) (this hospital) attended the deceased from October 1, 1960 to Oct 14, 1960 , that (I) (we) last saw the deceased alive on Oct 14, 1960 , and that death occurred at — M, from the causes and on the date stated above.			
22a. SIGNATURE J. Edwin Fassett		22b. DATE SIGNED —	
22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22d. ADDRESS 227 Pine St-Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/60	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Trappe Cem. Md.		23d. LOCATION (City, town, or county) Trappe (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James D. Smith		25a. REC'D BY REGISTRAR DATE OCT 24 '60	
		25b. REGISTRAR'S SIGNATURE James E. Evans	

2221.51 ~~do not file~~

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

11360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1136

1. PLACE OF DEATH
a. COUNTYDorchester, Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

410 Dorchester, Ave.

3. NAME OF
DECEASED
(Type or print)

4. SEX

5. COLOR OR RACE

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

13. FATHER'S NAME

Levin J. Neucomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank and date of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a).Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(b)DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY
PERFORMED?20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

(City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opiniondeath resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Dr. John Mace Jr.

22b. DATE THEREOF

Burial 10/13/1960.

22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Dorchester Memorial Park

Cambridge, Maryland

22d. LOCATION (City, town, or country) (State)

24d. REC'D BY REGISTRAR

24e. REGISTRAR'S SIGNATURE

Le Compte Funeral Service, Cambridge, Md.

DATE OCT 17 '60

Arthur S. Krause

TO DEPT.: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/591. PLACE OF DEATH
a. COUNTYDorchester, Co.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge, Md.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

410 Dorchester, Ave.

First

Middle

Levin

W

Never married

Never married Divorced Divorced

8. DATE OF BIRTH

10/5/1897

9. AGE (In years last birthday)

63 yrs.

10. IF UNDER 1 YEAR

11 months

19 days

60 hours

15 min.

11. IF UNDER 24 HRS.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. MOTHER'S MAIDEN NAME

James Island, Maryland

Sarah Fraizer

Address

Mrs. Anna Newcomb, Cambridge, Md.

14. INTERVAL BETWEEN
ONSET AND DEATH

15 min.

15. WAS AUTOPSY
PERFORMED?YES NO

16. SOCIAL SECURITY NO.

17. INFORMANT

18. INFORMANT

19. WAS AUTOPSY
PERFORMED?YES NO 20. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opiniondeath resulted from: Natural causes Accident Suicide Homicide Undetermined manner

22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

23. LOCATION (City, town, or country) (State)

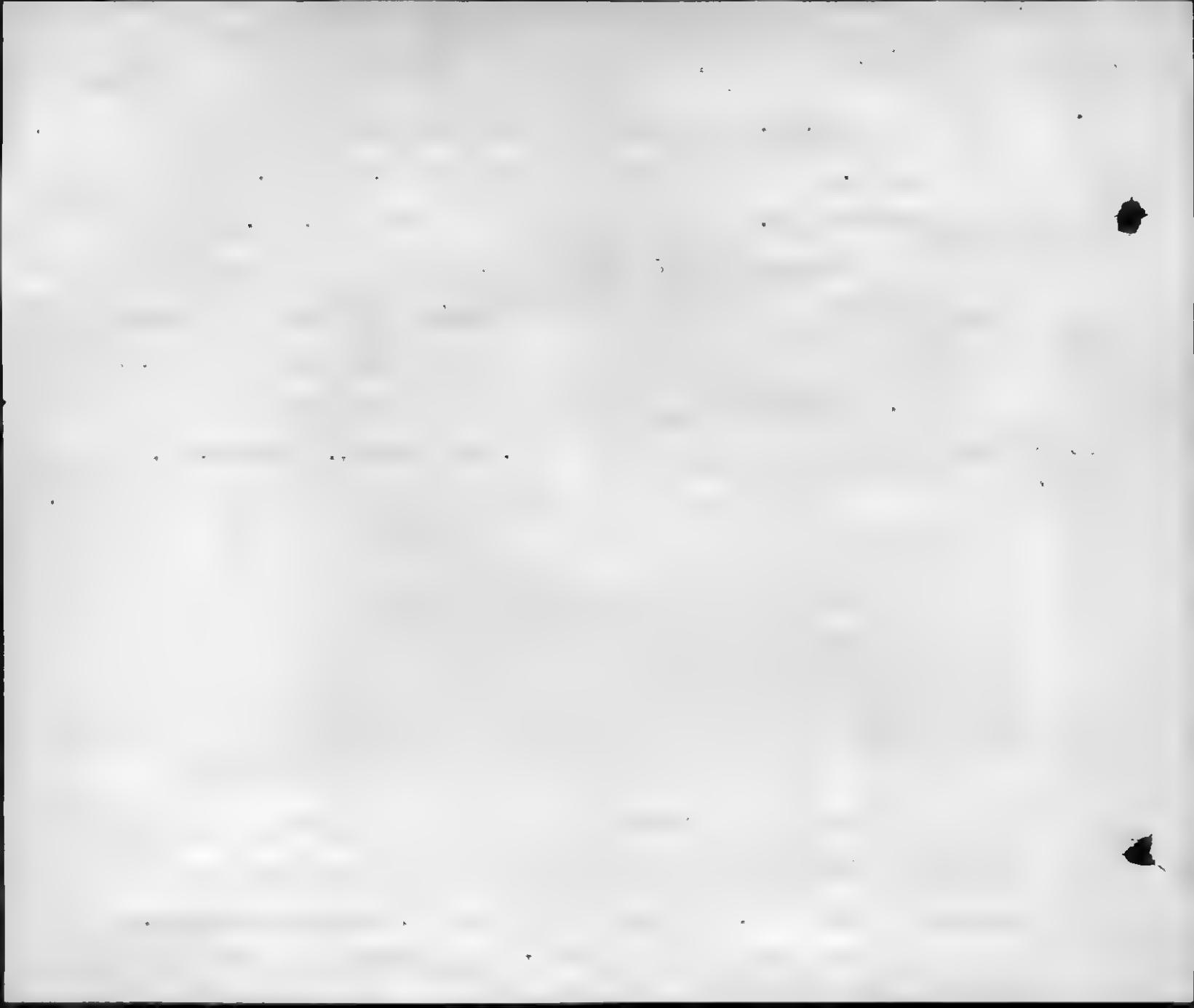
24. REC'D BY REGISTRAR

25. REGISTRAR'S SIGNATURE

Le Compte Funeral Service, Cambridge, Md.

DATE OCT 17 '60

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11351

CERTIFICATE OF DEATH

Reg. Dist. No. 11337

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 3	
3. NAME OF DECEASED (Type or print) Marald		d. STREET ADDRESS Rural	
First Marald		Middle Nielsen, Jr.,	Last October 19, 1960
4. DATE OF DEATH Month October Year 1960	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 5, 1893	9. AGE (In years lost 67 yrs.) Months Years	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Philadelphia	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Marald Nielson, Sr.,		14. MOTHER'S MAIDEN NAME Alice Stevenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 167-16-6057	17. INFORMANT Mrs. Evelyn M. Nielson, Cambridge, Md., R.D. 3	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Cardiovascular Rethal Decubensation 3 weeks Coronary Heart Disease 2 yrs	
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/29/60, 19, to 10/19/60, 19, that I last saw the deceased alive on 10/4/60, 19, and that death occurred at 11:35 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D. ADDRESS (Street, city or town, state) 136 Race St DATE SIGNED 10/20/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Old Saints Cemetery
22d. LOCATION (City, town, or county) Philadelphia County, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Alvin Wetzel, 501 No. Eastern Willow Grove, Pa.		24. REGISTRAR'S SIGNATURE Arthur S. Kline	
VS A15 (4) 15M 9/55		ADDRESS REG'D BY REGISTRAR DATE OCT 26 '60	



1
FOR STATE
HEALTH DEPT

M

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11364 MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11338

1. PLACE OF DEATH
a. COUNTY

Dorchester

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cambridge

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Edgell

5. SEX

6. COLOR OR RACE

Female

White

13. FATHER'S NAME

Charles Edgell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

217-16-9220 Eastern Shore State Hospital Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

782.4
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH
1 wk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I e. 19. WAS AUTOPSY
PERFORMED?

Fracture neck femur, left
20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

YES NO

Slipped and fell to floor.

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 10 AM p.m. 4/23/60 19

20d. INJURY OCCURRED
White at work Not White at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hospital

Cambridge

Dor.

Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

MEDICAL CERTIFICATION
EXAMINER'S
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23. FUNERAL DIRECTOR

John Mace Jr.

Oct. 8, 1960

Hill Crest Cemetery

ADDRESS

J. J. FRAMPTON & SON

FEDERALSBURG

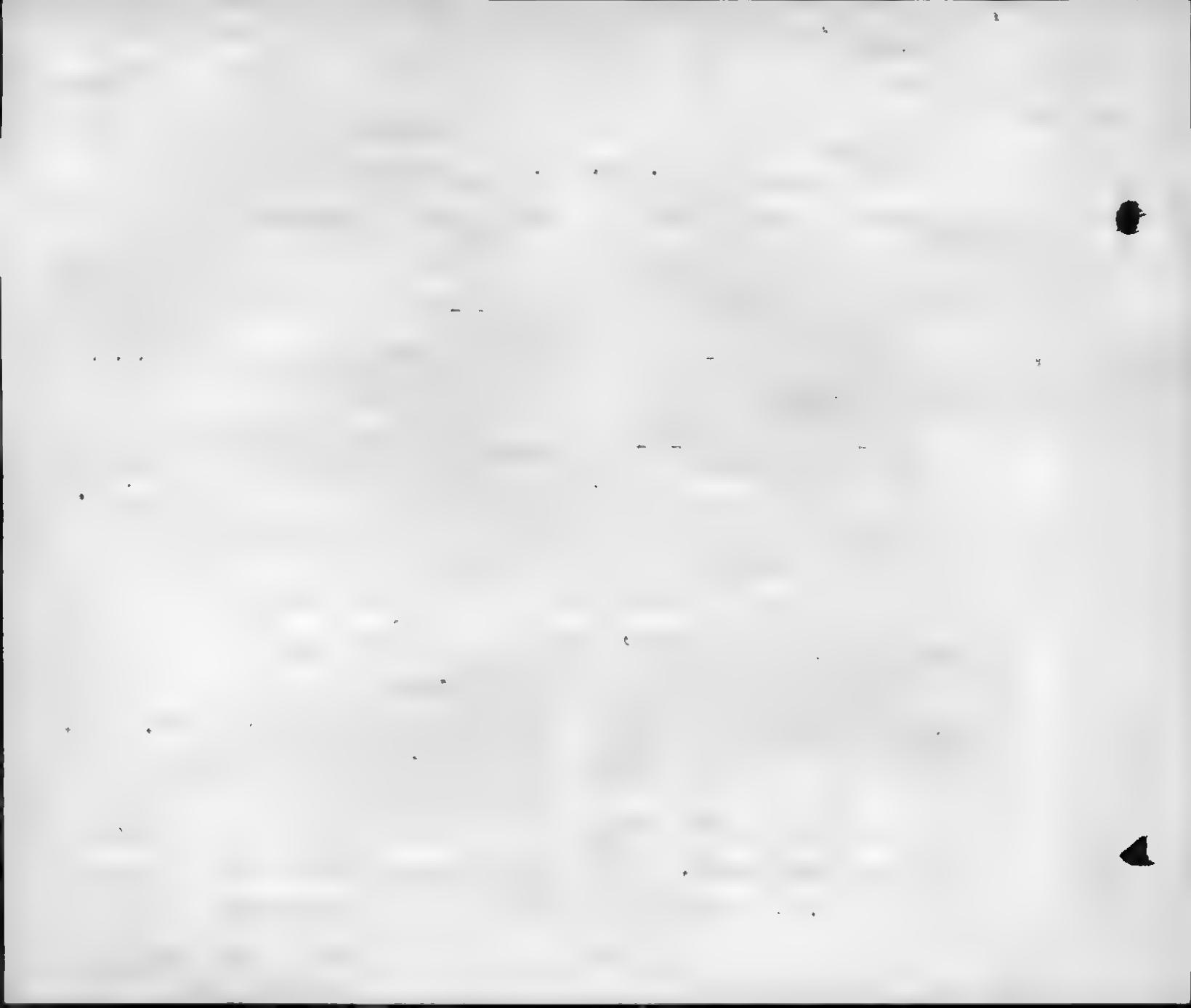
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

OCT 10 '60

Arthur S. Kraus

DATE SIGNED
10/6/60



FOR STATE
HEALTH DEPT.

M

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11330

1. PLACE OF DEATH a. COUNTY Dorchester	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland	b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bural Cambridge	d. STREET ADDRESS R.F.D. 3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Willie	First	Middle	Last				
4. DATE OF DEATH Oct. 4, 1960	Month	Day	Year				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1920	9. AGE (In years last birthday) 40 yrs.	f. IF UNDER 1 YEAR Months	g. IF UNDER 24 HRS. Hours	h. Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farmhand	11. BIRTHPLACE (State or foreign country) Alabama	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Macon Phillips	14. MOTHER'S MAIDEN NAME Mattie Stroudamire	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Irene Phillips RT. 3 Cambridge, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 58 Perit nitis, cerebral							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO (b) Cholecystitis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Maco</i>							
EXAMINER'S NAME (Type) John Maco Jr. M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/10/60							
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 10/9/60	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	22d. LOCATION (City, town, or country) Cambridge	Dorchester	Md.	(State)	
23. FUNERAL DIRECTOR St. Clair Funeral Cam	ADDRESS Cambridge	24a. REC'D BY REGISTRAR OCT 18 '60	24b. REGISTRAR'S SIGNATURE C. E. K. K.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

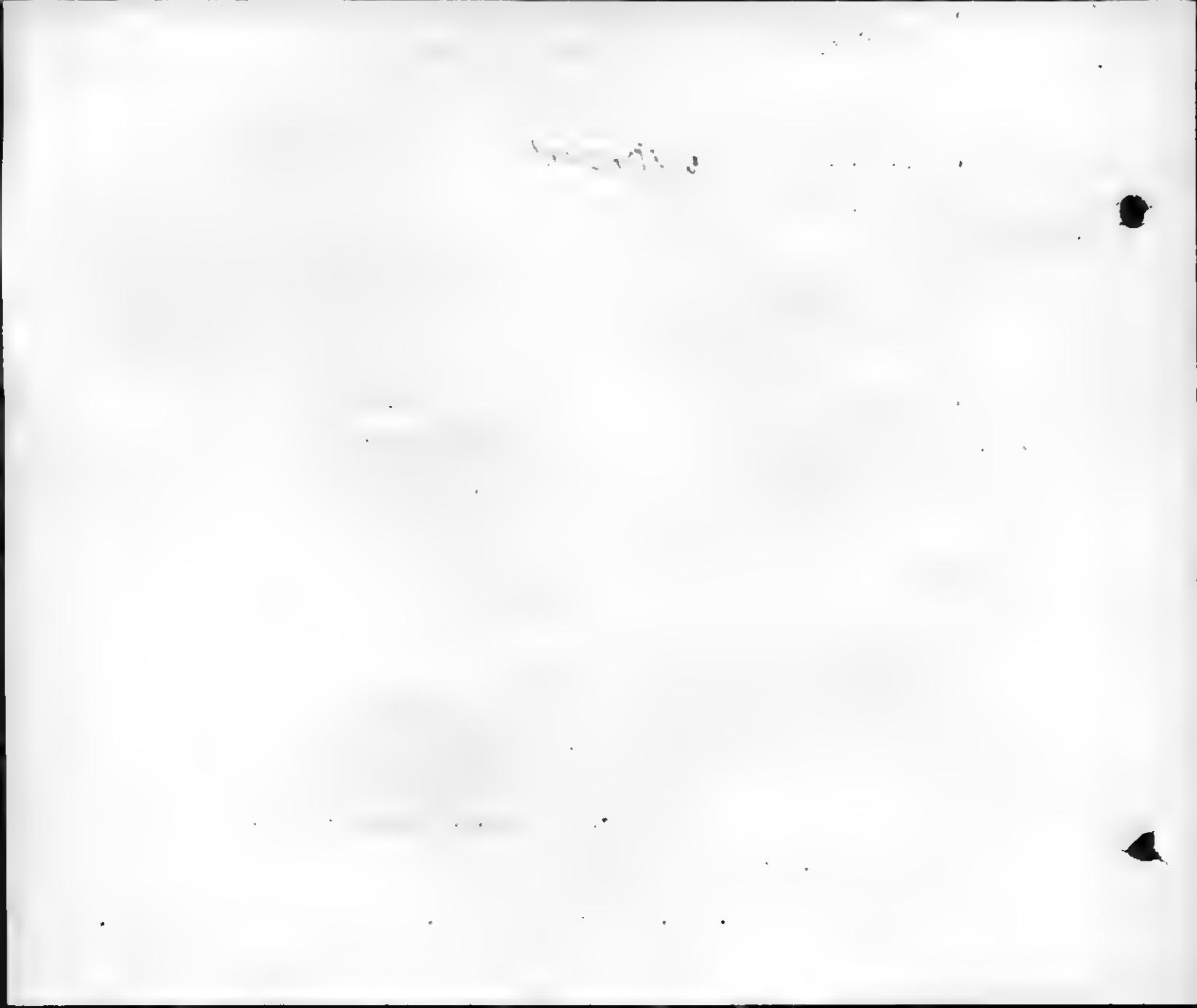
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11340**

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Forde, W. Pritchett		4. DATE OF DEATH Month Oct Day 22 Year 1960	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX M		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Mar 1 1894		9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Waterman	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unknown) 16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital records		18. INTERVAL BETWEEN ONSET AND DEATH Unk	
19. WAS AUTOPSY PERFORMED? NO YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. MEDICAL CERTIFICATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) Cambridge (County) Md. (State) 10-22-65
21. I certify that I attended the deceased from Oct 18 , 1960, to Oct 22 , 1960, that I last saw the deceased alive on Oct 21 , 1960, and that death occurred at 12:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. E.S.S. Hospital, Cambridge, Md. DATE SIGNED 10-22-65	
ACTUAL SIGNATURE Thomas J. Dredge		PHYSICIAN'S NAME (Type) Thomas J. Dredge MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 10/24/1960	22c. NAME OF CEMETERY OR CREMATORIAL St. Thomas Church Yard
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		22d. LOCATION (City, town, or county) Bishops Head, Maryland	24a. REC'D BY REGISTRAR NOV 4 '60
		24b. REGISTRAR'S SIGNATURE Constance	



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11363

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11341

1. PLACE OF DEATH
a. COUNTY

Dorchester, Co.

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge, Maryland.

c. LENGTH OF STAY IN 16

MARYLAND
D/O/A

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Maryland Hospital.

3. NAME OF
DECEASED
(Type or print)

First Middle

Roscoe

R. Rauark

4. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Waterman

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

1/22/1897

13. FATHER'S NAME

Augustus Rauark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes, give rank, dates of service)

No

No

No

Mrs. Roscoe Rauark, Husdon, Maryland.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

1 HR.

420
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER 10/31/60

DATE SIGNED

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/29/1960.

22c. NAME OF CEMETERY OR CREMATORIUM

Spedden's Cemetery

22d. LOCATION (City, town, or county)

Cambridge, Maryland

(State)

23. FUNERAL DIRECTOR

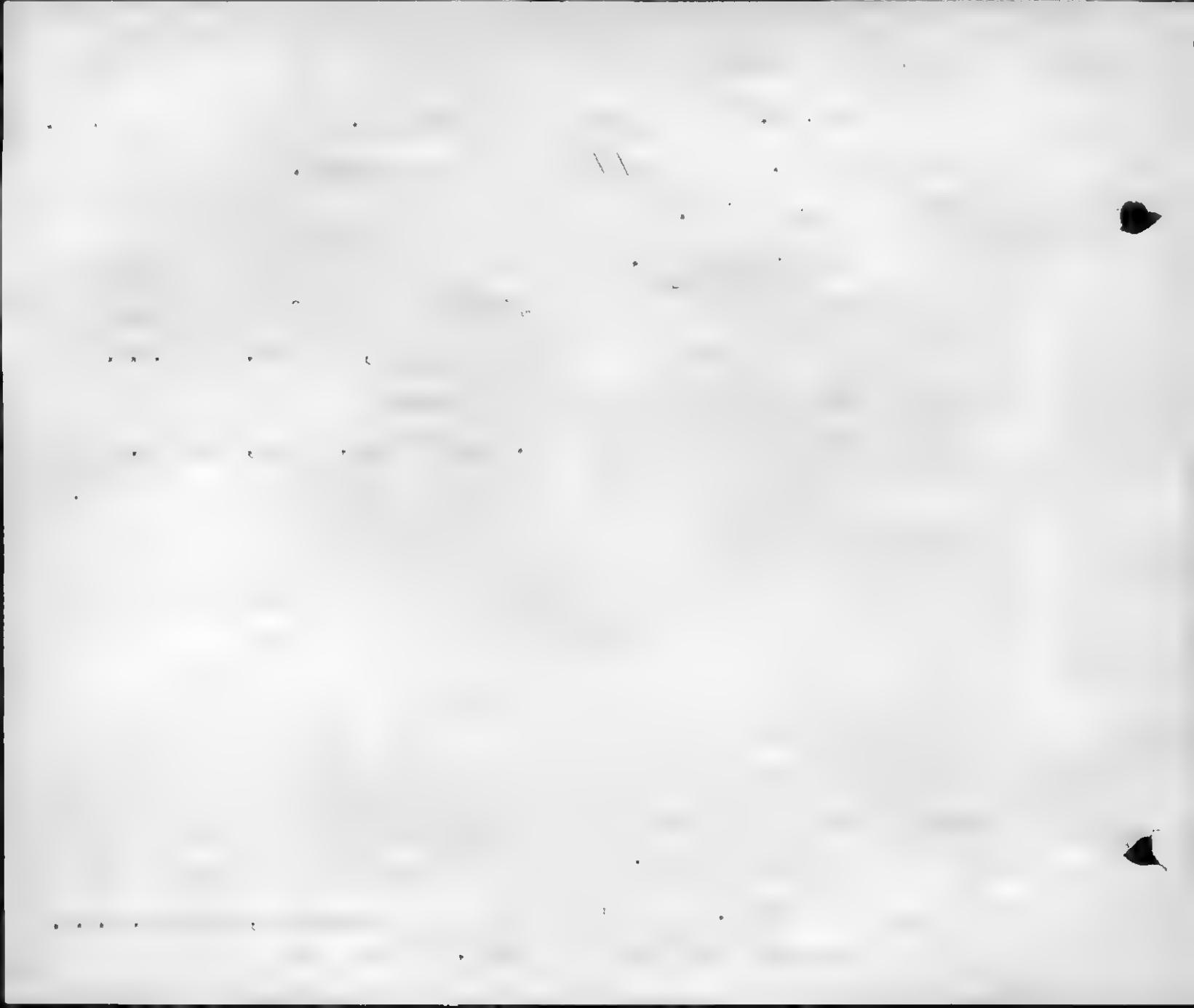
Le Compte Funeral Service, Cambridge, Maryland.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

R.F.D.

Orville S. Frazier



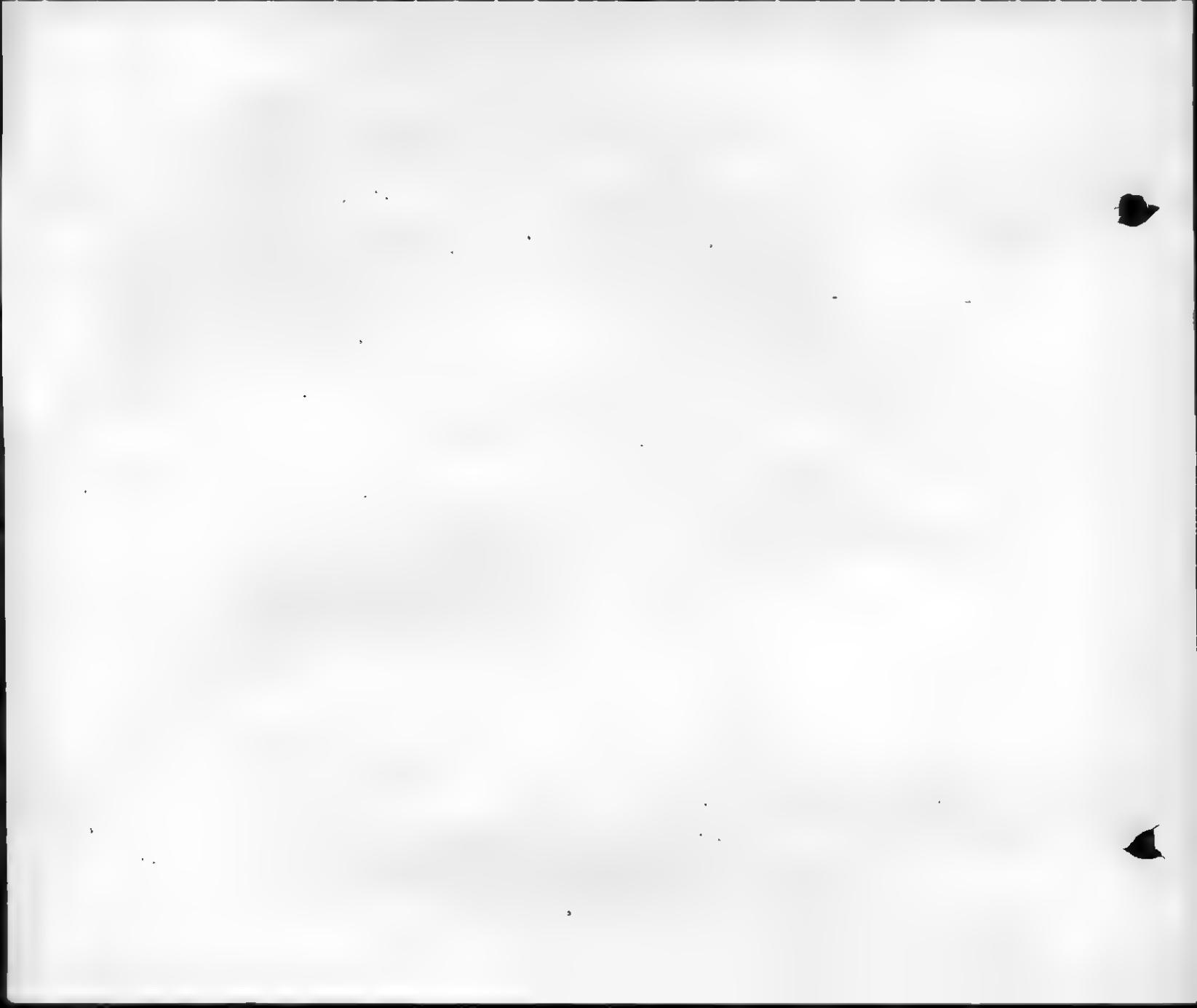
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11366

CERTIFICATE OF DEATH

11342

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ESTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THEODORE SHEA		4. DATE OF DEATH OCT. 10, 1960	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 15, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL JAMES SHEA		14. MOTHER'S MAIDEN NAME MARY DOWD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN NO		16. SOCIAL SECURITY NO. 215-01-5810	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG. 28 1960 to OCT. 10 1960 , that (I) (we) last saw the deceased alive on OCT. 10 1960 , and that death occurred at 6 PM , from the causes and on the date stated above			
22a. SIGNATURE Ettore De Filippis		22b. DATE SIGNED OCT. 10, 1960	
22c. PHYSICIAN'S NAME (Type) ETTORE DEFILIPPIS		22d. ADDRESS EASTERN SHORE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 13-60	
23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial Park		23d. LOCATION (City, town, or county) (State) W. Boston, Suffolk Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James H. Batten Jr., of Batten Bros., Centerville, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11354

CERTIFICATE OF DEATH

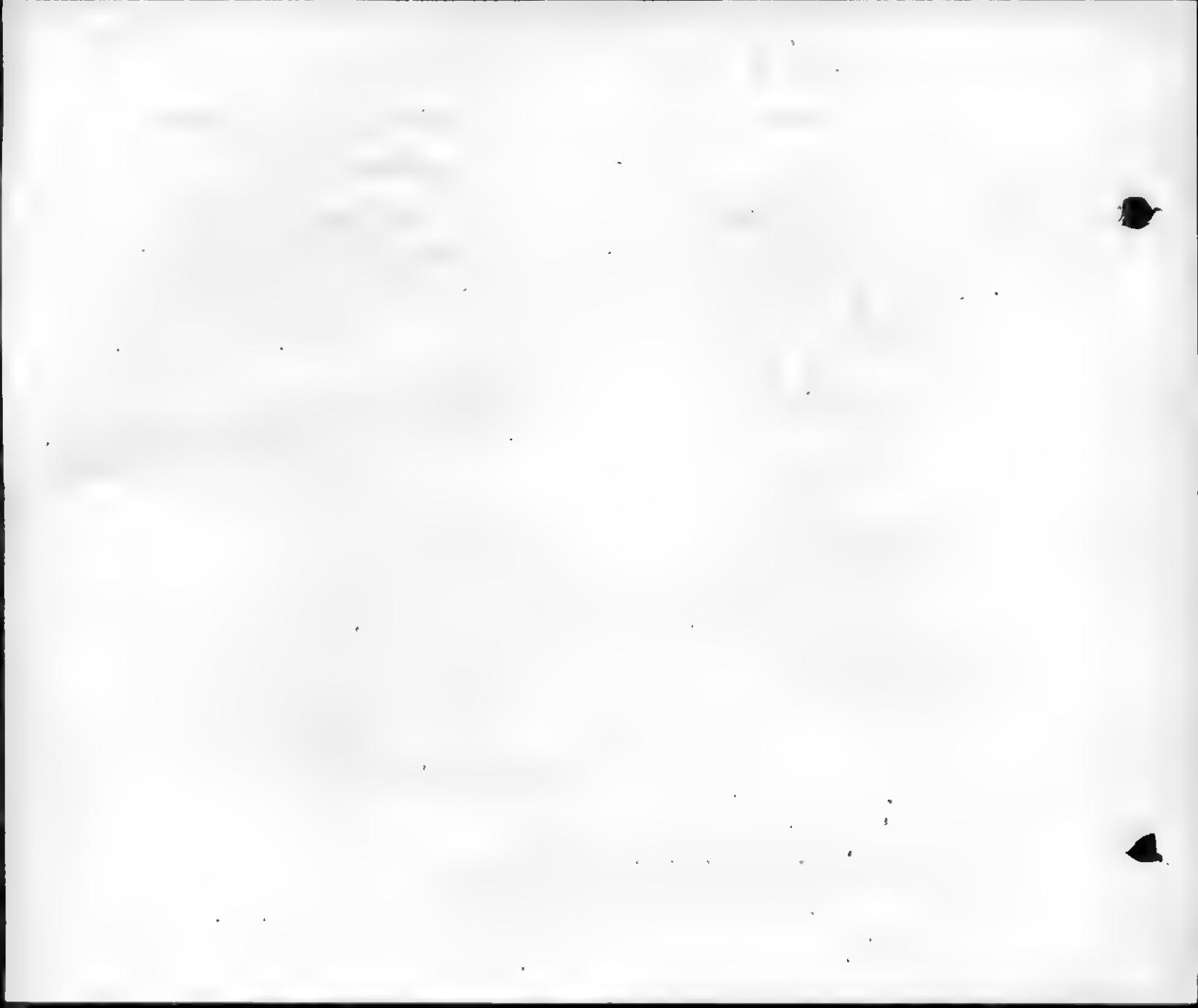
11343

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 253 Race street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
3. NAME OF DECEASED (Type or print) Sadie		Middle Stewart	4. DATE OF DEATH Month October 10, 1960
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1871
9. AGE (In years last birthday) 89	10. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (State or foreign country) Lakesville, Dor., Co.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Alfred E. Stewart		14. MOTHER'S MAIDEN NAME Mary Frances Foxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	Address Miss Lowene Simmons, 253 Race St., Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO PNEUMONIA - 3 days duration.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-11-45 to 10-10-60 , that I last saw the deceased alive on 10-9-60 , and that death occurred at 5:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue			
ACTUAL SIGNATURE <i>Albert E. Bunker</i>		DATE SIGNED 10-10-60	
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		CAMBRIDGE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Oct. 12, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Sherman</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE OCT 13 '60
			24b. REGISTRAR'S SIGNATURE <i>Carroll S. Turner</i>



FOR-STATE
HEALTH DEPT.

Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59MARYLAND STATE DEPARTMENT OF HEALTH
11367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11344

1. PLACE OF DEATH

a. COUNTY

Derchester, Co.
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Williamsburg, Maryland.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

None

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH10
Month
Day

29 19 60

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

2/25/1973

9. AGE (in years
last birthday)

87

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Store Keeper

10b. KIND OF BUSINESS OR INDUSTRY

General Mercantile

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

George Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or dates of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a):

782.4

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

Myocardial Failure

INTERVAL BETWEEN
ONSET AND DEATH
2 days

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED
11/1/60ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)Burial
11/2/1960.

23. FUNERAL DIRECTOR

ADDRESS

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIALY

22d. LOCATION (City, town, or country)

(State)

Gethsemane Church Yard

ADDRESS

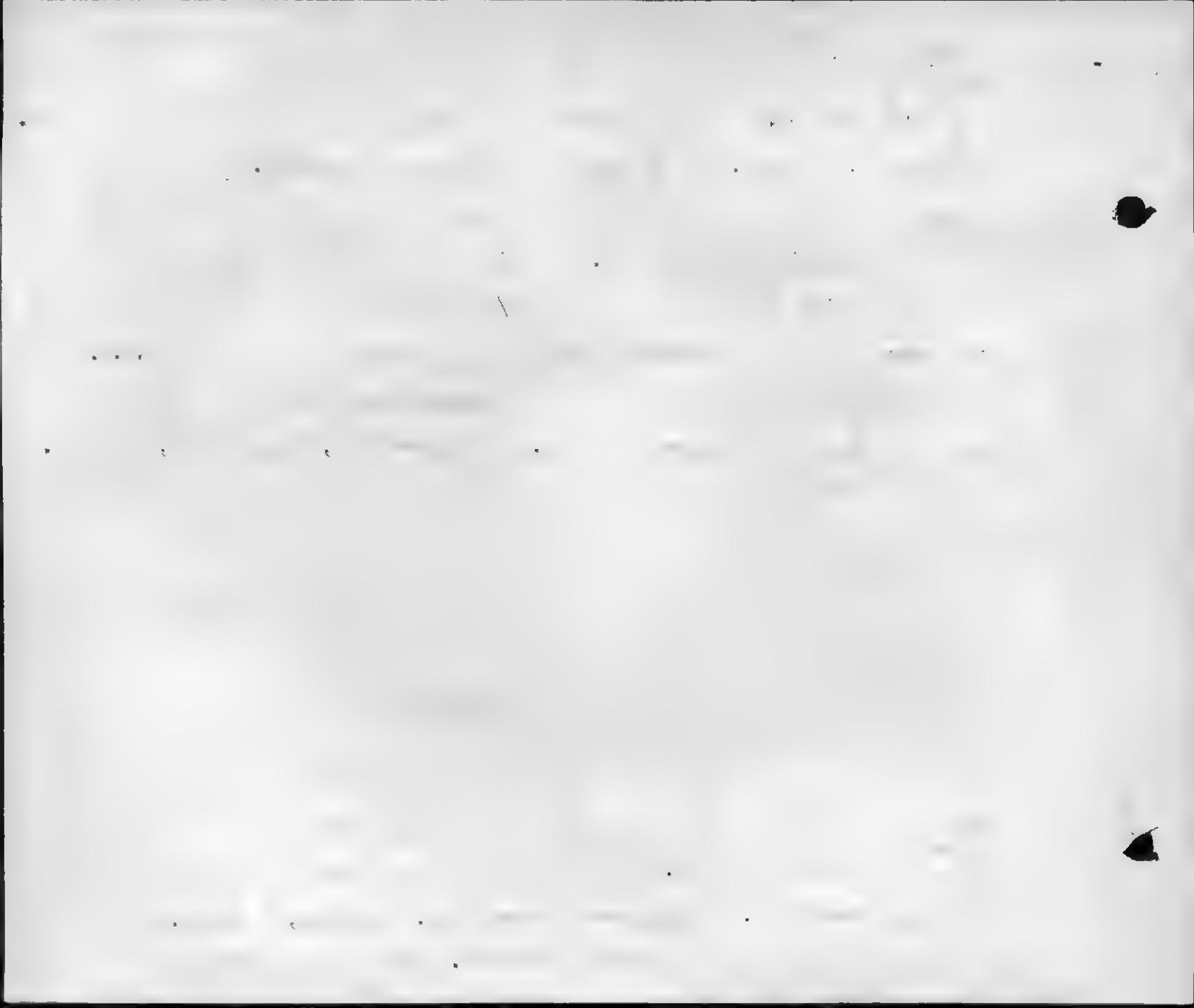
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Le Compte Funeral Service, Cambridge, Maryland.

DATE NOV 9 '60

Cuthbert S. Thomas



M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

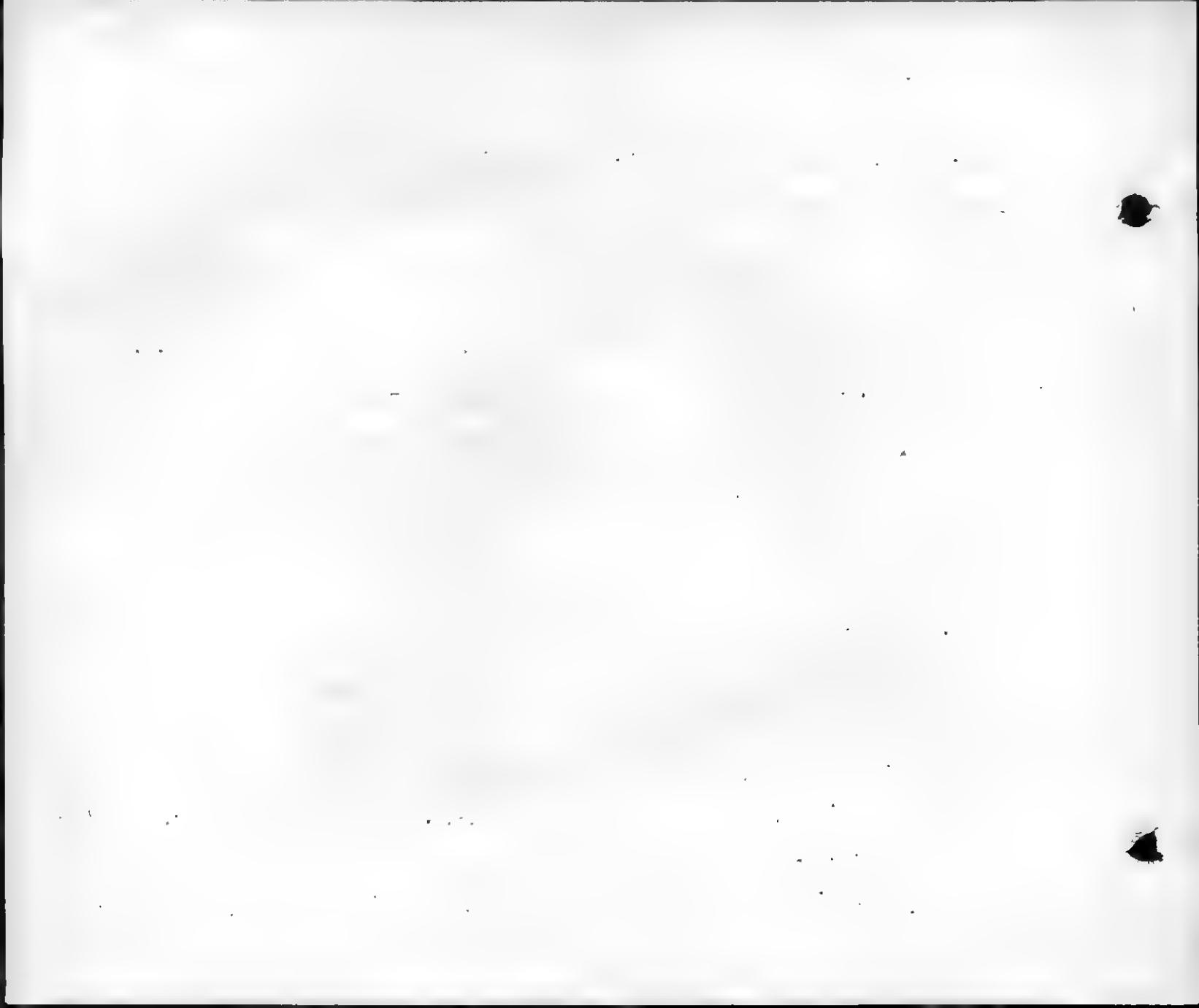
11368

CERTIFICATE OF DEATH

11345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 6 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS 19 -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CORNELIA		First	Middle	Last	4. DATE OF DEATH STERLING	Month	Day	Year	
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/70	9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 90	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Sterling		14. MOTHER'S MAIDEN NAME Harriet - UNKNOWN		INFORMANT		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. HOSPITAL RECORDS Hospital records		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Chr. Brain Syndrome due to senile brain disease, with psychosis									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chr. Brain Syndrome due to senile brain disease, with psychosis							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 10/21/60		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/8 , 19 53 , to 10/21 , 19 60 , that I last saw the deceased alive on 10/21 , 19 60 , and that death occurred at 10:15 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 10/21/60							DATE SIGNED		
ACTUAL SIGNATURE Thomas J. Dredge		M.D. E.S.S. Hospital, Cambridge, Md. 10/21/60							
PHYSICIAN'S NAME (Type) Thomas J. Dredge									
22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial Oct. 23 1960		22c. NAME OF CEMETERY OR CREMATORIAL Crisfield		22d. LOCATION (City, town, or county) Crisfield		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James L. Hinman		ADDRESS Crisfield		24a. REC'D BY REGISTRAR DATE OCT 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

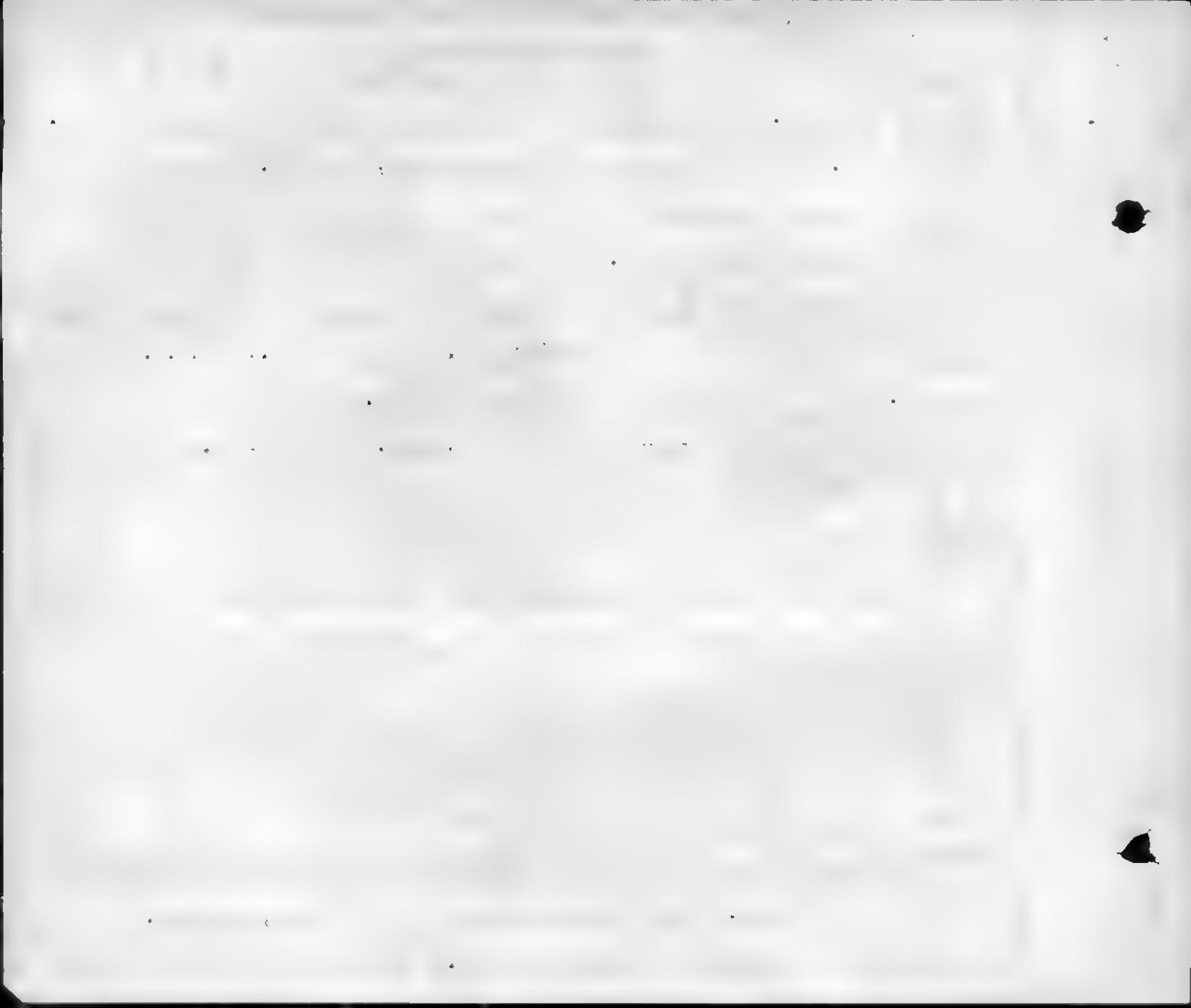


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11346
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Toddville, Maryland		d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Winnie		First	Middle	Last	4. DATE OF DEATH 10 15 19 60	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED X	8. DATE OF BIRTH 8/1/1884	9. AGE (In years lost birthday) 76	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Food Inspector		10b. KIND OF BUSINESS OR INDUSTRY Tidewater Fisheries Comm.		11. BIRTHPLACE (State or Foreign country) Toddville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Rausme B. Todd				14. MOTHER'S MAIDEN NAME Roxie A. Todd					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-34-3843		17. INFORMANT Gillis S. Todd, Toddville, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 491 X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Bronchopneumonia (Bilat) Fibrinous lungs</i>		INTERVAL BETWEEN ONSET AND DEATH 5 days			
(b) DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 104 Locust St		(County) Cambridge	(State) Maryland
21. I certify that I attended the deceased from 10/10/1960 to 10/15/1960 that I last saw the deceased alive on 10/15/1960 , and that death occurred at 4 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. H. Hanks</i> ADDRESS (Street, city or town, state) 104 Locust St DATE SIGNED 10/18/1960									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/1960.		22c. NAME OF CEMETERY OR CREMATORIAL Family Cemetery		22d. LOCATION (City, town, or county) Toddville, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland		ADDRESS		24a. REC'D BY REGISTRAR NOV 4 '60		24b. REGISTRAR'S SIGNATURE <i>W. H. Hanks</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11369

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13811

1. PLACE OF DEATH
a. COUNTY

Dorchester

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge, R.D. 1

c. LENGTH OF STAY IN lb
8 hours

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Found Dead on County Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

Oliver

Washington

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

November 3, 1904

9. AGE (In years)
last birthday

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waterman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hoopersville, Md.

13. FATHER'S NAME

Samuel M. Tyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Susan Hooper

18. DATE OF DEATH

October 7, 1960

19

20. AGE (In years)
IF UNDER 1 YEAR
last birthday

55 yrs. Months Days Hours Min.

21. CITIZEN OF WHAT COUNTRY?

U.S.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

982 Focal hemorrhage in encephalopathy.

Conditions, factors, which
gave rise to immediate cause

(a), stating the underlying
cause last.

DUE TO

(b)

Blow on head.

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

?

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Unknown how blow on head occurred.

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 7.17 1960
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Nr. Cambridge Dor. Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John Mace Jr. M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

11/21/60

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Oct. 9, 1960

22c. NAME OF CEMETERY OR CREMATORIAL

Southern Church Cem.

22d. LOCATION (City, town, or country)

(State)

Hoopersville, Maryland

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE DEC 15 '60

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11356

CERTIFICATE OF DEATH

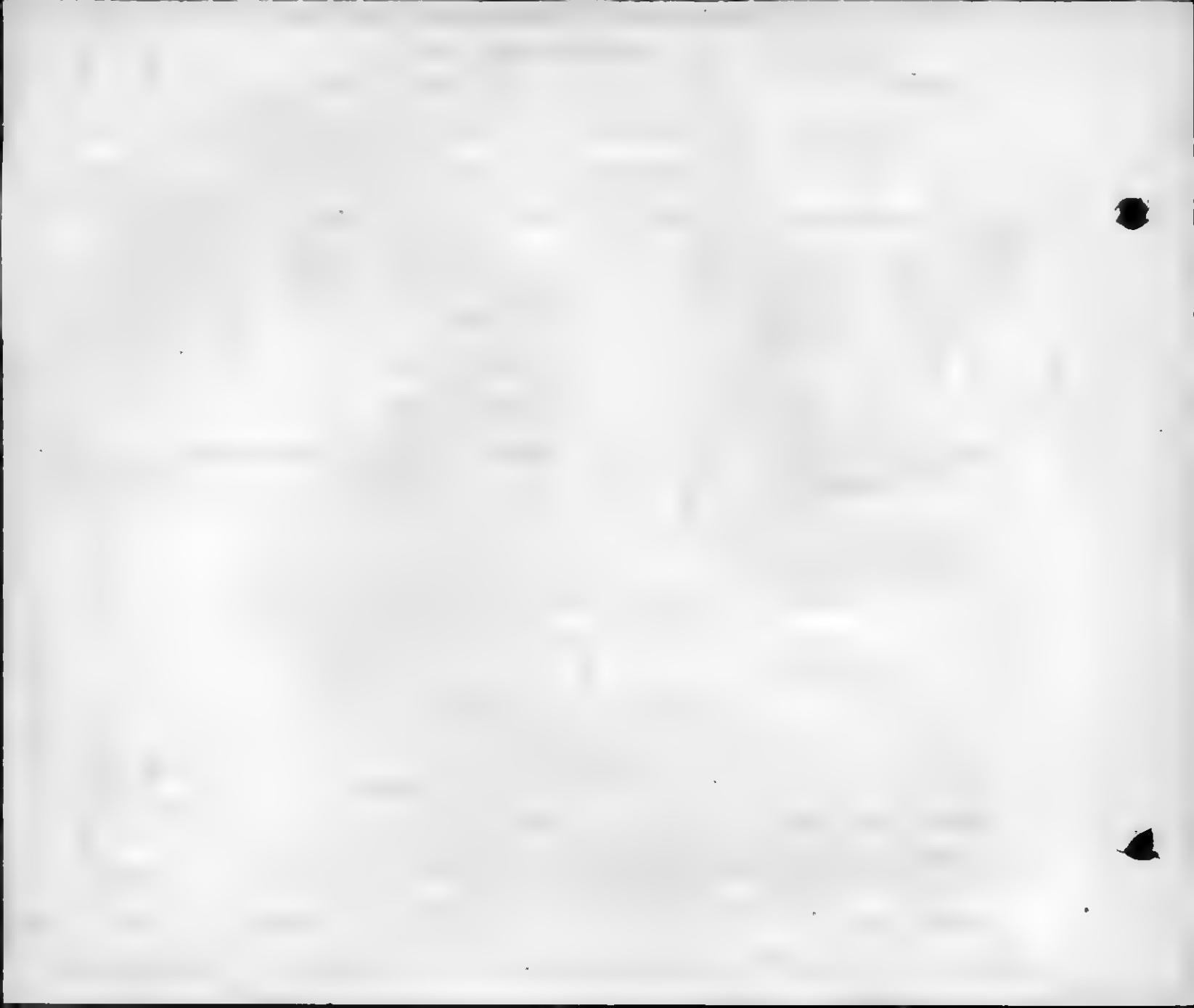
11347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 61bri ge		c. LENGTH OF STAY IN 1b 30 hrs. 39 mins. Cambridge 13	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. STREET ADDRESS Hambrooks Blvd. 1	
3. NAME OF DECEASED (Type or print) First Middle Last Van Curen		4. DATE OF DEATH October 3 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-60
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 39 Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Morris Arthur Van Curen		14. MOTHER'S MAIDEN NAME Jessie Charles Edward Stennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jessie Van Curen - Hambrooks Blvd., Cambridge, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 173.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1, 1960, to 16-3, 1960, that I last saw the deceased alive on 10-3, 1960, and that death occurred at 3 1/2 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE 1233 - M.D. DATE SIGNED 10-4-60			
22. PHYSICIAN'S NAME (Type) Dr. Milour N. Baumann - 3 Church Street, Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth J. Bowes		24a. ADDRESS Cambridge, Md.	
24b. REC'D BY REGISTRAR DATE OCT 6 '60		24c. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11370 11348

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford, Maryland.		c. LENGTH OF STAY IN 1b 17 Years.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford, Maryland.	
d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emily Louise Mc Gowan Van Diver		First	Middle
Last		4. DATE OF DEATH 10	Month
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9/6/1900		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistical Reports		10b. KIND OF BUSINESS OR INDUSTRY Publishing	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence McGowan		14. MOTHER'S MAIDEN NAME Emma Germane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. Vernon Van Diver, Woolford, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized carcinomatosis			
DUE TO (c) Adenocarcinoma, right breast			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) (Radical amputation, right breast, Dec. 1958)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) -----		(County) ----- (State) -----	
21. I certify that (I) (Signature) attended the deceased from Dec. 16, 1958 , to Oct. 22nd, 1960 , that (I) (Signature) last saw the deceased alive on Oct. 22nd, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above			
22a. SIGNATURE Eldridge H. Wolff		M.D. <input type="checkbox"/> ATTENDING PHYS. # <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> <input type="checkbox"/> STAFF PHYS. Oct. 24th, 1960	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M. D.		22d. ADDRESS 15 Locust st., Cambridge, Maryland	
23a. CEMETERY OR CREMATORIUM REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/1960	23c. NAME OF CEMETERY OR CREMATORIUM Grenmont Cemetery
23d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE NOV 4 '60	25b. REGISTRAR'S SIGNATURE Caring S. Thomas



FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11349

1. PLACE OF DEATH
a. COUNTY

Dorchester

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cambridge

c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Eastern Shore State Hospital

MARYLAND

3. NAME OF
DECEASED
(Type or print)

First

Middle

Edna

M.

Varnes

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Female

White

WIDOWED DIVORCED

6-22-86 (?)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

William J. Varnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

14. MOTHER'S MAIDEN NAME

Sara Hooper

U.S.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN
ONSET AND DEATH
4 days9047
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Fracture neck left femur

4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20c. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell against bed rail

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 9.30 AM 10-26-6020d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hospital

Cambridge

Dor.

Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

10/31/60

ACTUAL
SIGNATURE

John Mace Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE



FOR STATE
HEALTH-DEPT.

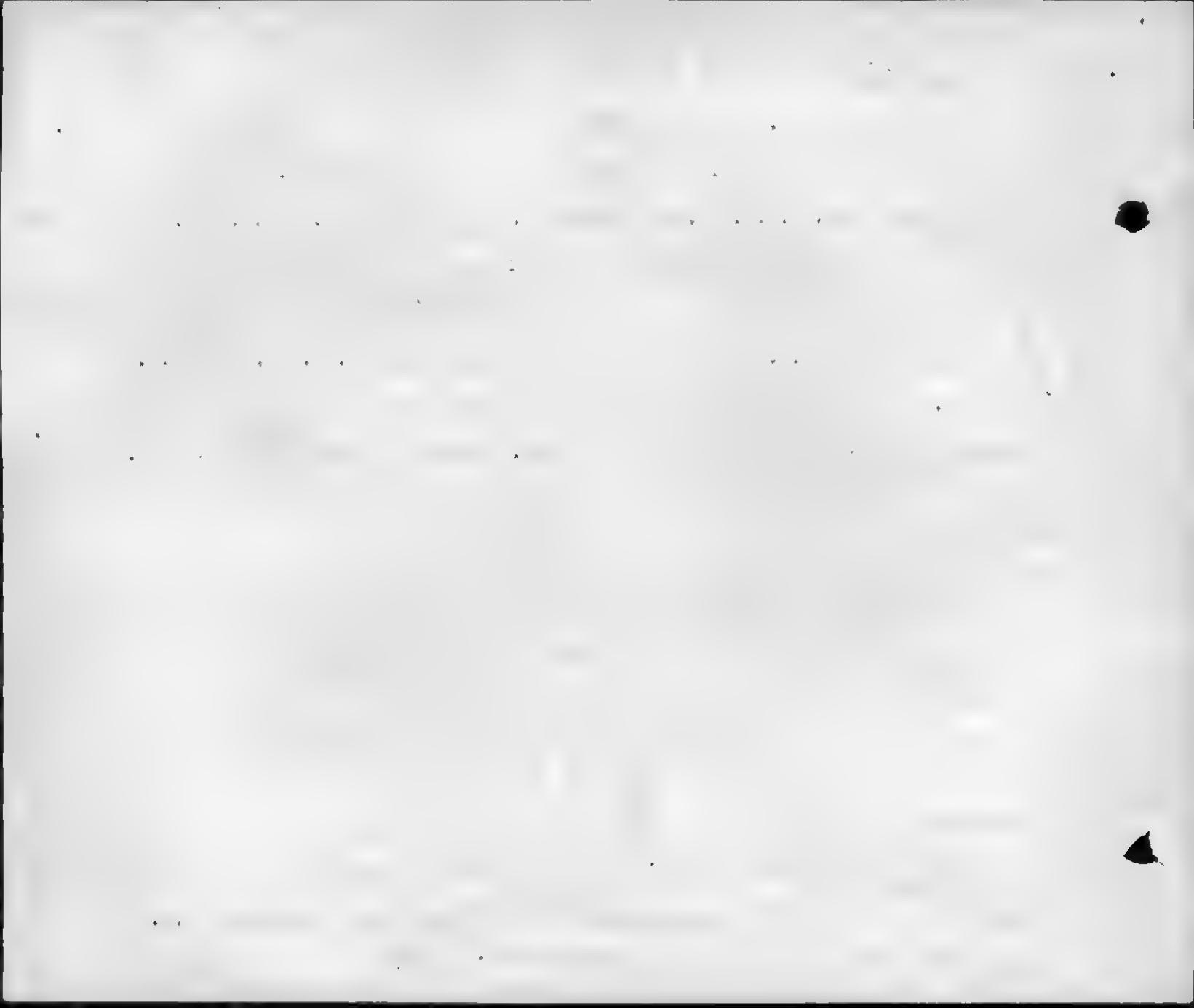
TO DEPT. MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11350

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Dorchester, Co.		b. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Dorchester, Co.	
Cambridge, Maryland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
10 Years		c. STREET ADDRESS Cambridge, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Hambrooks Blvd., R.F.D. # 1, Cambridge, Md.		Hambrooks Blvd., R.F.D. # 1, Cambridge, Md.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Last 10 24 1960	
Charles Leroy Walker		Month Day Year	
5. SEX Male		5. COLOR OR RACE White	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. DATE OF BIRTH 11/19/1885	
WIDOWED <input type="checkbox"/>		8. DIVORCED <input type="checkbox"/>	
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY Railroad	
Chesapeake Ohio R.R.		11. BIRTHPLACE (State or foreign country) Charles City Co. W. Va.	
13. FATHER'S NAME G. Michael Walker		14. MOTHER'S MAIDEN NAME Alta Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service) Yes W-1		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Charles Walker, Hambrooks, Blvd., Cambridge		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 mins.	
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10/26/60	
22e. BURIAL, CREMATION REMOVAL (Specify) Burial		22f. DATE THEREOF 10/27/1960	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery		22d. LOCATION (City, town, or country) Washington, D.C.	
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland.		24e. REC'D BY REGISTRAR 24f. REGISTRAR'S SIGNATURE Cuthbert S. Thomas DATE NOV 4 '60	
VS. A15ME 5M 7/59			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT.

11357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11351

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

8 WKS.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cambridge Hosp.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Hayward T. WEBB

4. DATE
OF
DEATH

October 20 1960

5. SEX

Male

6. COLOR OR RACE

Col.

7. MARRIED NEVER MARRIED WIDOWED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

64 yrs.

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Doctor

10b. KIND OF BUSINESS OR INDUSTRY

Medical Doctor

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis Asbury Webb

14. MOTHER'S MAIDEN NAME

Rosa friend

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

—

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Miss Doris Webb, Easton, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

491X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

Terminal bronchopneumonia

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Fractures of Pelvis

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED
October 20, 1960ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

(State)

VS. A15ME
5M 7/59

24c. DATE

OCT 24 '60

24d. DATE

OCT 24 '60

Arthur S. Kraus

27088

27088

1
FOR STATE
HEALTH DEPT.

TO DEATH
please execute the certificate, writing the word "Pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11373

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11352

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		d. STREET ADDRESS 05X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edgar	Middle S.	Last Willis	4. DATE OF DEATH October 9 1960	Month October	Day 9	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1878	9. AGE (In years 82 If under 1 year Months Years	10. IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick mason, retired		10b. KIND OF BUSINESS OR INDUSTRY Brick laying		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Willis		14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Records E.S.S. hospital		Address Cambridge, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420 Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH instant							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis ?							
DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH ?							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.							
EXAMINER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Denton		22d. LOCATION (City, town, or county) Denton, Md (State)	
23. FUNERAL DIRECTOR J. Virgil Mace Jr.		ADDRESS		24a. REC'D BY REGISTRAR OCT 11 1960		24b. REGISTRAR'S SIGNATURE John S. Mace	
VS. A15ME 5M 7/59				DATE			

